Virtues in medicine

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VIRTUES IN MEDICINE

BY

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Presented in partial fulfillment of the requirements
for the degree of
Master of Arts
University of Montana
1992

Approved by

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Date
May 26, 1992

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The primary objective of this thesis was to investigate the possibility that virtues are essential for physicians. Evidence for this claim was developed from a review of the history of virtues in medicine, including modern medical education, and from analyses of six medical case histories from my own experience as a physician. The contributions of virtues were assessed in contrast to those of ethical principles. It was shown that the virtues are essential for physicians and that they have a complementary role to that of ethical principles.

The remainder of the thesis is a preliminary effort to develop a virtue theory for medicine. It was suggested that a virtue theory has two bases, a moral psychology and a concept of the good. The thesis presents a moral psychology of virtues based on the Aristotelian model of virtues as certain sorts of habits, dispositions, or character traits. It was argued that the good could be restricted to the good of medicine. The good of medicine was derived from characteristics of professional-client relationships and clarified by the purposes of medicine, the nature of medical practice, and the experiences of patients. It was then argued that the moral virtues of physicians are benevolence, respectfulness, trustworthiness, compassion, care, honesty, humility, courage, conscientiousness, patience, perseverance, diligence, equanimity, and justice, combined with the intellectual virtue of practical wisdom. A definition and discussion of each virtue followed. The thesis concludes with considerations of some criticisms of virtue ethics.
ACKNOWLEDGEMENTS

This thesis is offered in partial fulfillment for a Master’s Degree in Philosophy at the University of Montana, where I have been a part-time student in philosophy since 1984. Over those years I have deeply appreciated the opportunity to work with the members of the Department of Philosophy, who have been extraordinarily encouraging, supportive, and helpful. I appreciate the efforts of several persons who have been department secretary over those years. They have been uniformly cheerful and helpful.

Producing this thesis has been a difficult, trying, and, ultimately, very educational process, as all such exercises should be. I have learned more from my mistakes than my successes. Such is life. This project has had, and will have, profound influences on my future teaching efforts and on my own sense of what sort of person I want to be. I am grateful for that outcome.

I particularly owe much to Professor Richard Walton, who has contributed much time and effort to this project. I am deeply grateful for his vigorous criticism and innumerable helpful suggestions. Professor Albert Borgmann has given me much support and encouragement over the years, as well as making many contributions as a member of my thesis committee. Professor John Moskop, of the Department of Medical Humanities at East Carolina University Medical School, whom I had the good fortune to work with while he was a visiting professor here in 1988, is on my thesis committee and has given me many useful suggestions. Professor Tom Huff gave me helpful comments in the early stages of this project. Professor Burke Townsend, who was kind enough to join the thesis committee late in the project, gave me useful suggestions about the general shape of this project. I take credit for all the imperfections in this work, but many of the good points I owe to the above individuals.

I express my deepest gratitude to Janet Teem Stone, who has supported my move into philosophy from the beginning. She has been extraordinarily patient, tolerant, flexible, and committed to helping me complete this objective. I am also deeply appreciative of the understanding and support over the years of my children—Lisa, Nancy, Anna, and John. I thank Neill Norman for his support and for his sense of humor. Finally, I thank my Missoula cardiology colleagues for their support, and for their tolerance of my needs to pursue philosophy, particularly W. Stan Wilson, M.D., my colleague and dear friend.

John Root Stone
Missoula, Montana
Spring, 1992
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   Moral Theory, Principles, Casuistry, and the "Care Orientation: A Brief Overview
Scholarship in biomedical ethics is primarily a late twentieth century phenomenon. This burgeoning field has focused on working out the implications for health care of ethical principles such as beneficence, respect for autonomy, nonmaleficence, and justice. Evaluation of these principles has yielded helpful guidelines, or "action-guides," for moral issues encountered by practicing physicians and others. The processes of obtaining informed consent and of determining that a patient should not be resuscitated are two instances in which such guidelines have been important. But ethics based on principles is under fire. Some scholars have argued that the so-called principles are not part of any systematic theory. Others have recently argued that principles are too abstract; that they are insufficiently tied to actual cases. One form of this response has been to advocate a return to casuistry. Casuistry holds that morality should be based in analysis of paradigmatic cases, from which maxims, or guidelines for moral obligation, are developed. The maxims are then applied to other cases by reasoning through analogy to the paradigmatic cases. Adherents to the "care orientation" also argue that attention to specific cases is essential in morality, but, in contrast to casuistry,
emphasize the relationship issues and needs of the persons, among other themes, in each case. For further background on moral theories, principles, casuistry, and the care orientation, I have included an appendix to this introduction. The background sketch in the appendix will help demarcate the place of principles in the milieu of moral theory, facilitating comparison of principles to other approaches. I have included discussions of casuistry and the "care orientation" because they may offer important criticisms of the principles-based approach. This sets the stage for discussion of the virtues.

In the last decade, I began trying consciously to apply ethical principles to my medical practice. The principles clarified my obligations as a physician and were helpful in some specific cases. But I finally concluded that the principles were inadequate resources for my work. My failures or successes seemed much more dependent on my character traits (or lack of them) such as compassion, humility, and conscientiousness, i.e., virtues. The purpose of this thesis is to examine the validity of this impression that the virtues are essential for physicians.

The primary outcome of this effort is my conclusion that virtues are, indeed, essential for physicians. The history of the virtues in medicine and analyses of cases from my own medical experience provide preliminary evidence for this claim in chapters one and two. Drawing from this material, chapter
three presents several arguments intended to prove that the virtues are essential for physicians. The primary objective of this thesis is then completed.

Other evidence developed in chapters one and two indicated the need for a secondary objective of this work. Not only is the teaching of the virtues incomplete, inadequate, and haphazard in medical education; the medical education experience positively teaches vices to some physicians. These deficiencies in medical education suggest the need for an explicit virtue theory for medicine, from which could be determined a reasonably complete set of physicians' virtues.

It is well beyond the scope of this work to develop a complete virtue theory for medicine. But it is possible to sketch out the components of such a theory. The second part of this essay, chapters four through seven, attempts to meet this secondary objective. Chapter four provides a detailed explanation of the nature of a virtue, based on the Aristotelian model. I argue in chapter five that an adequate virtue theory for medicine can be derived from the good of the professions, and further clarified by considering the purposes of medicine, the nature of medical practice, and patients' experiences of illness. A list of physicians' virtues is then derived. Chapter six defines and explains each of the virtues. Chapter seven concludes this section by considering some criticisms of a virtue theory for medicine. Some
refutations of the criticisms are offered, but my work on the criticisms is not as mature as the rest of this effort. The thesis is summarized in chapter eight, which also points out some directions for future work.
NOTES

1. The prime example of this focus has been Tom L. Beauchamp and James F. Childress' *Principles of Biomedical Ethics*, 3d ed. (New York: Oxford University Press, 1989).

2. See, for example, Beauchamp and Childress, 7.

3. Henceforth, "physicians" will refer to physicians engaged in direct patient care--practicing physicians. "Medicine" will refer to medicine as it is practiced by physicians.


7. Carse, 6.

CHAPTER ONE

A History of the Virtues in Medicine

Virtues have had a place in western medicine since at least the fifth century, B.C.. Hippocrates of Cos, a physician, was probably born about 460 B.C.. Most of the works known as the Hippocratic Corpus were written from 430 to 330 B.C.. The Hippocratic Oath makes some reference to virtue. It requires that physicians live a life which is devoted to patients' good, that they have self-control and that they avoid injustice. There is considerable controversy about which Greek physicians took the Oath and how important it was to physicians. Western medicine returned to Hippocrates in the Enlightenment, as noted below, but the Oath now has very little impact on the lives of modern physicians.

The Hippocratic corpus was written at a time when the concept of virtue had already undergone considerable transformation. The word, "virtue," did not originally refer to moral qualities or sexual purity, concepts with which we now associate "virtue." The Greek word for virtue, arete, originally carried the range of meanings contained in the general concept of "excellence." Excellence could apply to humans, other beings, and things. Homer often referred to arete in his stories, which were created about the eighth century, B.C.. But, Homer was referring to concepts of arete...
of earlier times. Homer used arete to refer to a variety of excellences, such as excellence in running, in warfare, etc.. By the time of Athens in the fifth century B.C., the meaning of arete had evolved to the point that Plato's concept of the virtuous man was tightly associated with his concept of the virtuous citizen. Plato associated the virtues of temperance, courage and wisdom with the three parts of the soul. The fourth "cardinal" virtue, justice, insured that each part of the soul had its proper function. Plato's concepts of the soul, advanced in the Republic, were consonant with Greek concepts that health represented a balance of the parts of the body. Thus, "virtue arises from a harmony of constituent parts of the soul, which are organized for the best performance of living." Aristotle, however, had a significantly different view of the virtues. His conception was that virtues are developed by practice. Possession of the virtues enable men to fulfill their natural function, resulting in eudaimonia, a state of happiness.

After classical Greece, concepts of virtue particularly evolved in Stoicism, which was extremely influential in ancient Rome. Moving away from Greek associations of virtue with health and the body, Stoicism held that what was really important was moral virtue, regardless of the state of the body. Whatever life's ravages, one could achieve peace through moral excellence in one's soul. Particularly important for the development of concepts of virtues of
physicians was the increasing emphasis in Rome on "the brotherhood of all mankind," which promoted the development of virtues that served humanity.¹⁷ Scribonius Largus, a Roman physician of the first century, A.D., thought compassion, philanthropy and competence were essential features of physicians, as well as an egalitarian duty to treat all people, whatever their means or character.¹⁸ Scribonius understood action with compassion to be attempts to preserve patients' humanity and believed that virtuous doctors would not willfully harm patients if compassion is a central virtue. Physicians are united by their promises to do good, which motivate them to be virtuous. Since patients are susceptible to harm when they are ill, their vulnerability should be respected by physicians. Scribonius' virtue theory was based in the good of the patient, with objectives of moral behavior evolving from his concepts of what kind of person the physician should be.¹⁹ A very influential Roman physician, Galen (A.D. 130?-200?) thought the best physicians were philosophers who led a moral life, attempted to relieve suffering, treated the poor and published what they knew for the benefit of humanity.²⁰

Christianity developed new concepts of virtues.²¹ The virtues were developed from the basic virtues of love of God and of faith in God. Examples were patience, kindness, goodness and faithfulness.²² Jesus, of course, was the paradigm person. His followers tried to exemplify the central
virtues of faith, hope and love, wedded with the secondary virtues of compassion, humility, etc. Aquinas (c.1225-1274) later synthesized themes from Augustine (354-430), Ambrose (c.340-397), Boethius (c.480-524), and Aristotle, suggesting that faith, hope and love come from God, and that 'natural' virtues like prudence, courage and temperance came from human action. Aquinas proposed that there were three categories of virtues: intellectual (intelligence, wisdom, etc.), moral (cardinal virtues) and theological virtues, but the theological virtues were in man due to God's grace. People achieved intellectual and moral virtues by finding a mean between extremes. These former virtues were developed through practice. The theological virtues, however, came from God and were not dependent on persons' actions.

The main thrust of Christian virtue, until the sixteenth century, was the concept that people should be like Jesus in their "thoughts, actions and character." Physicians' work in healing had some importance, but was not to be overemphasized because suffering was also valued in the Christian tradition. The Catholic Church, from the Fourteenth to the Sixteenth century, held that the features of the virtuous physician were competence, keeping up to date on literature and techniques, diligence, faithfulness, motivation for the good of the patient, and avoidance of experimentation, the latter proscribed especially if merely for the physicians' curiosity.
The Reformation was followed by changes in the foundations of medical concepts and in ideas about physicians' virtues. Reformation leaders denied that the virtues could be prescribed by the Church, advising that each person should learn the virtues by studying the *New Testament*. Physicians came to emphasize metaphysical concerns less, following Locke and Hume, although metaphysics was revived in the Romantic movement. Enlightenment physicians of the eighteenth century recommended a return to Hippocrates. A new focus of medicine was on empirical data. There was much disagreement about virtues and duties in the Enlightenment, but there was general acceptance of the four Platonic virtues of wisdom, moderation, courage, and justice, and the three Christian cardinal virtues of faith, hope, and charity. One author thought that the essential virtues for physicians were "patience, philanthropy, sympathy, mildness, modesty, courtesy, industry and the love of order. . . ." The general goal was a balance among the virtues, which were thought to be derived from love of God and neighbor. Longolius wrote in 1767 that physicians were to provide "a steadfast attention to both body and soul in all bodily accidents of a living person," acting upon their concern for patients' humanity and a helpful disposition. Trust in one's physician, derived from the physician's moral character, was thought to have healing power. Discord among the virtues was expected and was solved by physicians' judgment. Vices to be avoided included "gluttony,
drunkenness, gambling and scandalous speech." It is not clear how often these virtues were followed by physicians. Satires by Swift, Sterne and Voltaire, for example, played on images of greedy and vicious physicians. Eighteenth and nineteenth century medical texts derived physicians' virtues from their duties or obligations. Virtues were thought to be habits which reduced the stress of repeatedly resisting temptations in making appropriate moral decisions.

John Gregory (1724-1773) developed a general medical ethics, including principles, duties, virtues and etiquette, published as Lectures on the Duties and Qualifications of a Physician. Gregory developed physicians' moral responsibilities from sympathy, which he thought was a "natural disposition to experience of the feelings of another." The moral appropriateness of a physician's act was then judged by the pleasure or pain sensed in the physician's sympathetic feelings for the patient. An action's moral status stemmed from the pleasure or pain the physician felt for the patient as a result of interaction with the patient. Gregory held that sympathy "...makes us feel for the distresses of our fellow creatures...and...incites in us the most powerful manner to relieve them." Gregory believed that physicians must not only recognize their duties, but that adherence to those duties required a certain sort of moral character. Gregory's conception was that the right sort of moral character would eliminate repeated moral struggles to
follow the duties. The right sort of moral character consisted of having the virtues, which reduced physicians' motivations to serve their self-interests. Virtues then served the objectives of physicians in their routine medical work. For example, prudence in delivering bad news guides the physician to the best timing and the doctor's humanity minimizes the harm to the patient. Gregory developed a systematic, comprehensive medical ethics which emphasized patients' welfare and virtues of physicians.

The nineteenth century history of Anglo-American medical ethics can be seen as the destruction of Gregory's work. The undermining of Gregory's work began with Thomas Percival's Medical Ethics of 1803, which had a strong influence on the original American Medical Association (AMA) Code of Ethics of 1847. Percival's work was designed primarily to enhance interprofessional relations and to solve conflicts among physicians, in contrast to Gregory's focus on patient welfare. In Percival's scheme, physicians' attitudes and qualities become instruments to advance the self-interests of physicians. In Percival's view,

Hospital physicians and surgeons should minister to the sick, with due impressions of the importance of their office, reflecting that the ease, the health, and the lives of those committed to their charge depend on their skill, attention and fidelity. They should study, also, in their deportment, so to unite tenderness with steadiness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect and confidence.

These words were essentially incorporated into the 1847 AMA code.
Percival's work suited the AMA's objectives of establishing the power and control of the medical profession. This move to disconnect virtues from the primary obligations of physicians is likely part of the reason that virtues have such a peripheral role in modern medical education and bioethics.

American medical education was quite haphazard until the early twentieth century, when there were major moves toward the standardization of medical education, including emphasis on a curriculum based in science. Personal characteristics of prospective medical students were considered important, but medical school admission committees found character traits difficult to assess. In a lecture in 1907, F.C. Shattuck, physician-in-chief of the Massachusetts General Hospital of Harvard Medical School, told the Yale Medical School graduating class that characteristics important for doctors included "knowledge, thoroughness, common sense, character, enthusiasm, sympathy, and honesty." Abraham Flexner saw the inadequacy of a merely scientific education for medical practice, despite the widespread impression that his 1910 polemical medical school review only promoted the value of science in medical school education. Flexner noted the importance of physicians' "insight and sympathy." In later years Flexner thought the rigid medical curriculum had too much science, with insufficient emphasis on the humanistic side of medicine.

As this century progressed, medical school faculty gradually became less satisfactory models of physicians' virtues as the role of the "teacher-investigator" was emphasized in contrast to the
previous teacher-practitioner." The primary emphasis for faculty was further training in the conduct of clinical research. Patient care became "a chore because it took time away from research." Medical school faculty spent less and less of their time focusing on the features of good patient care and in providing it, in the process becoming less interested, less knowledgeable, less skilled, and less able to manifest and to teach virtues of physicians. But some physicians continued to understand the importance of the virtues and physicians' qualities.

The continued influence of William Osler's life and writings on twentieth century physicians is some testimony to their sense that they need qualities for their practices beyond the scientific emphasis of ordinary medical education. Osler was a charismatic man who has been a model for many twentieth century American physicians, including me. A Canadian who worked at McGill and the University of Pennsylvania, Osler was one of the founding physicians of the Johns Hopkins University School of Medicine. With a strong background in pathology, Osler was a leader in internal medicine. The author of an extremely successful textbook of medicine, Osler was extraordinarily influential on his younger colleagues and very effective in getting physicians to collaborate and form organizations around common interests. As documented in copies of Osler's extensive correspondence, published in Harvey Cushing's encyclopedic *The Life of Sir William Osler*, Osler constantly encouraged his colleagues and juniors to study this or to try that, to collaborate with this person or with that one, to
travel and otherwise to improve themselves." Osler appears in his writings and in Cushing's biography as a strong, kind, thoughtful leader who tirelessly tries to help his associates and who is an exemplary physician. As W.S. Thayer, a disciple of Osler and a later leader at Johns Hopkins, stated,

"He was a great teacher. But his main strength lay in the singular and unique charm of his presence, in the sparkling brilliancy of his mind, in the rare beauty of his character and of his life, and in the example that he set to his fellows and to his students. He was a quickening spirit."

A superb clinician and bedside teacher, Osler was the model of a balanced man. He was widely read in the classics and a bibliophile. He wrote many essays and delivered many speeches. He eventually left Hopkins to become a Professor of Medicine at Oxford and died in England at age 70 in 1920. My hypothesis is that modern physicians have studied Osler in part because he was a paradigmatic model of a virtuous physician. This is certainly a primary reason why I have been attracted by his story.

I first heard of Osler about 1962. As a junior or senior college student, going into medical school, an older friend of mine at Emory University told me about an inspirational collection of essays written by someone named William Osler. I did not read any of Osler's work then, but I have had a continued relationship with it, and with his story, since. My relationship with the man's essays and with his life began after I entered the Johns Hopkins Medical School, which is permeated by "Oslerian" lore. I have repeatedly returned to his essays for inspiration and insight. His
Life has often served as a paradigmatic model in my character development.

Although the mainstream of American medical education has continued to follow the scientific model, there has been continued concern about the relative roles of scientific medical education and personal characteristics of good doctors. Sir Robert Pratt stated in 1963 that

"Scientific thinking is a necessary but not sufficient condition of good doctoring. It needs other qualities: warmth, feeling, compassion, humor, patience, integrity, and understanding."

I entered medical school at Johns Hopkins in 1963. Science and scientific medicine were the predominant features of my medical school education, although in the first two years we had some introduction to the history of medicine, sociology, and anthropology pertinent to illness and to medical practice. There was some stress on virtues in my medical education and postgraduate training, but the faculty almost always discussed medical diagnosis, mechanisms of disease and scientific features of medical treatment. They clearly expected us to have honesty, diligence, and conscientiousness, and exemplified these virtues to some degree, but there were almost no conversations about these virtues." One practicing surgeon gave us a talk about personal qualities of good physicians when we were third year medical students. What I remember was how unusual this was, not what he said.

Virtues also were respected in postgraduate medical education, but rarely discussed or examined. I spent my first two
postgraduate years in internal medicine on the Osler Medical Service at Johns Hopkins Hospital. During that experience, I was taught that diligence, reliability, intellectual honesty, and courage were essential virtues of physicians. We exhibited courage by tolerance of emotional stress and of physical discomfort. The expected outcome of diligence was that we should get the patients taken care of whatever was demanded of us. If we had problems performing, we were deficient, not the system. One was to be above personal needs like rest, diversion, and the needs of spouses and children. Most of our examples were house officers who were the same age as we were, or a few years older. They were usually people who had gone through the same program and had acquired similar virtues. What they had usually not done was to reflect critically on these virtues, and they had minimal life experience to facilitate that reflection.

Bosk's field observations, in a major surgical training program, demonstrated that the faculty had stringent moral requirements of their house officers. The faculty were strong role models of moral qualities like honesty and acceptance of criticism. Dishonesty and resistance to criticism were tolerated less than technical mistakes, as the former were interpreted by the faculty to be fundamental character defects that would prevent a trainee from being an excellent surgeon, but the latter could usually be corrected through greater experience. As in my experience, Bosk found no formal discussion of the nature and expectations of physicians' moral character. Hauerwas believes

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that medical training is replete with teaching of the virtues, such as honesty and fidelity, and agrees with Bosk and my own observations that this training is not overt. 

This lack of formal attention to virtues is typical of modern American medical education. The virtues are a significant part of medical training, but they are rarely examined, inadequately emphasized, and insufficiently taught. Melvin Konner’s account of his recent medical school experience shows considerable deficiencies in the current teaching of virtues in one major medical teaching institution. Konner found the usual emphasis on diligence, conscientiousness, and intellectual honesty, but a glaring deficiency was the minimal focus on compassion, caring, respect for patients’ dignity and other virtues relating to humane care. Konner noted the crucial need for these latter virtues, but the primary role models were house officers, and these individuals were not selected for personal qualities like compassion and caring. Since some house officers and faculty verbally abused medical students, the former were being role models for vices. Good role models were uncommon, but those encountered had a powerful effect on Konner. The American Board of Internal Medicine has recently noted the lack of role models as a factor reducing humanistic qualities of internists.
NOTES


3. Many medical schools do not require that their graduates take the Hippocratic Oath and it is not required for state licensing or membership in any medical organization of which I am aware. I have rarely heard the Oath discussed by my colleagues.


6. After Virtue, 122.

7. After Virtue, 141.

8. After Virtue, 141.


13. Ferngren and Amundsen, 20. Edmund and Alice Pellegrino state that Scribonius' concepts may have been derived from Cicero's views about "duty, promise-keeping, and conflicts of obligation," presented in De Officis. Cicero subscribed to the classical virtues of wisdom, justice, courage, and temperance. These virtues were thought to be special features of man which distinguished him from animals. (Edmund Pellegrino and Alice Pellegrino, "Humanism and Ethics in Roman Medicine: Translation and Commentary on a Text of Scribonius Largus," in Literature and Medicine, ed. by D. Heyward Block and Richard M. Ratzan, (Baltimore: The Johns Hopkins University Press, 1988), 7:34.)

14. Edmund Pellegrino and Alice Pellegrino, 31-32. In his writing about contemporary medicine, Edmund Pellegrino uses concepts similar to those of Scribonius. Note Pellegrino's references to "wounded humanity," acting for the patient's good (24),

15. Ferngren and Amundsen, 19.


20. Amundsen and Ferngren, 40.


23. Quoted by Von Engelhardt, 66.


26. I use "vicious" to mean the person who is characterized by vice. Even the Hippocratic Corpus has essays which caution physicians against greed, advises them to adjust fees according to patients' means, and suggests that some work should be done without charge. (See G.E.R. Lloyd, "Introduction," *Hippocratic Writings*, 19.)


28. McCullough, 82.

29. John Gregory, cited in McCullough, 82.

30. McCullough, 83.

31. McCullough, 84. This reminds me of Emily Dickinson's poem about the importance of how truth is told, included in a missive from an older teacher to a student doctor:

Tell all the truth but tell it slant-
Success in Circuit lies
Too bright for our infirm Delight
The Truth's superb surprise
As Lightning to the Children ease
With explanation kind
The Truth must dazzle gradually
Or every man be blind–


32.McCullough, 86.
33.McCullough, 89.
34.T. Percival, Medical Ethics, or a Code of Institutes and Precepts Adapted to the Professional Conduct of Physicians and Surgeons, 1803, p. 71, quoted in McCullough, 87.

35.McCullough, 89.
36.McCullough, 90-91.
37.Ludmerer, 88-89.
38.Ludmerer, 121-122.

40.Abraham Flexner, quoted in Ludmerer, 182.
41.Ludmerer, 182.
42.Ludmerer, 105.
44.One window into important traits for practicing physicians in the first several decades of this century can be found in the stories of William Carlos Williams. Williams was a general practitioner for immigrant, poor families in New Jersey, as well as a prolific short story writer, novelist and poet. His tales in The Doctor Stories grippingly portray the virtues and vices of physicians, described in William's spare, earthy prose that seems to give the reader a look into these doctors' souls. Many of Williams' stories teach virtues by negative example, portraying behaviors that one would want to learn to control, modify or avoid. See William Carlos Williams, The Doctor Stories, compiled by Robert Coles (New York: New Directions, 1984).

45.Harvey Cushing, The Life of Sir William Osler (London: Oxford University Press, 1940). Cushing's biography, a tome of 1417 pages, including an index, was particularly responsible for maintaining Osler's influence. Cushing was a famous neurosurgeon who studied under Osler at Hopkins.

47. The interested reader may wish to browse through a copy of Osler's _Aeguaminitas and Other Papers That Have Stood the Test of Time_ (New York: Norton, 1963), or his _A Way of Life, An Address Delivered to Yale Students, 1913_ (Springfield: Thomas, n.d.).

48. Sir Robert Pratt, quoted in Stoeckle, 92.

49. This is what Bosk observed in a surgical training program. Moral virtues were important characteristics by which physicians were judged, and there was role modelling, but there was no overt discussion about the virtues. See Charles L. Bosk, _Forgive and Remember: Managing Medical Failure_ (Chicago: University of Chicago Press, 1979).

50. I remember a Sunday afternoon during my internship when we admitted a very ill man with a high fever. After getting his treatment started, I went out to interview his wife since the man was too sick to give much of his story. This courteous, kind woman and her children spent the afternoon there with me. The room was overheated on that winter day and I was sitting back in a padded chair. I would ask a question and then fall asleep during her answer, my pen scrawling down across the page. She would wait patiently and sympathetically until I awakened. I would apologize and ask her another question and fall asleep as she was answering. After an hour or two, I finally gave up with no helpful information, but some useful sleep. I worked with one intern the next year that fell asleep every night with his head on his typewriter. George would stay up typing his notes until early in the morning, when he would put his head down on his typewriter "for a brief nap" and remain there until we woke him for morning rounds.

51. As should be evident from what I will later propose to be fundamental virtues of physicians, I believe the set of virtues emphasized while I was at Hopkins was an insufficient base for being a good physician. Excessive emphasis on hard work and self denial, while ignoring other important virtues, does not equip physicians well for living good lives either as persons or as physicians.

52. For this and following, see Bosk, 38, 60, 140, 190.


54. These are my general conclusions from Konner's work. (Melvin Konner, _Becoming a Doctor: A Journey of Initiation in Medical School_ (New York: Penguin Books, 1987). See pages 24–25, 41, 153, 256, 263, 273, 282, 328, and 353 for examples of the points on which I base my conclusions.)

CHAPTER TWO

Analysis of Six Medical Case Histories

This chapter will show that physicians must have virtues. The evidence will be developed from six medical cases from my own experience. Five case histories are those of particular patients and one is a composite sketch of many similar cases. Each case is followed by an analysis which clarifies the issues, if needed; then assesses the pertinence or contribution of the ethical principles of justice, beneficence, nonmaleficence, and respect for autonomy; and then assesses the contributions of virtues. The discussion of the principles assumes definitions advanced by Beauchamp and Childress in their Principles of Biomedical Ethics. The definition of virtues has two parts. First, virtues are habits, dispositions, or character traits to feel or to act, and are developed by practice. Examples are compassion, benevolence, honesty, and courage. By "virtues," I mean moral virtues, except for practical wisdom, which is an intellectual virtue. Second, virtues are defined by the end, or the good, which they serve. In the case of medicine, the good is the benefit of patients.
CASE I:

Do it my way!

Mr. Smith (not his real name) exuded confidence and warmth. He breezed into my office in a suit, in his fifties, gray wavy hair well groomed. I was only in my thirties, my third or fourth year as a practicing cardiologist. He talked fast. He took charge....so I realized....later....much later.

Mr. Smith said: "I've been an alcoholic and recovered. I've made a million and lost a million."

Mr. Smith now had a problem that he couldn't solve alone. A few months before he had developed effort angina. His chest started hurting when he hurried or was in tense situations. His doctor had done an exercise test which suggested that he had significant narrowing of his coronary arteries. Mr. Smith was here to talk to me about getting coronary angiography, x-ray movies of the coronary arteries taken by inserting a catheter in his arterial circulation and injecting dye into each coronary artery.

Mr. Smith and I got along well--excellently, in fact. He seemed very open, his concerns, his life story almost transparent. We reviewed his medical history and I examined him, finding no other problems.

He got dressed and we met in my office to discuss cardiac catheterization, the procedure by which I could visualize his coronary arteries. I told him that I confirmed his doctor's impression that he unfortunately appeared to have coronary artery disease. His story and the significant electrocardiogram abnormalities on his exercise test, I said, indicated he might have very extensive and possibly life-threatening coronary artery disease.

"Let me tell you about the nature of the heart cath procedure," I said, launching into a sequence that I had thought out and felt good about initiating for this "informed consent" process we were beginning.

I had carefully followed recent publications on informed consent. Cases in the courts had led to commentaries in the medical literature with cogent advice to lay out all reasonable choices to patients, especially the nature and risks of any procedure they might have to undergo. Patients needed to understand what they were being advised by their doctor, if they were to make informed, autonomous choices. As I was increasingly coming to view myself as a patient advocate, the objectives of informed consent seemed just right.

I had also read studies reporting that patients had increased survival and reduced morbidity after surgical procedures if they were well educated about the nature of
the operation and what they would experience. Since cardiac catheterization is essentially a form of minor surgery, it was important to educate my patients about this procedure before they experienced it.

So I believed—as I tried to start my usual explanation of the coronary angiography procedure to J.

"You don't need to tell me about that. Don't bother," Mr. Smith quickly said. "I've had a number of friends who have had heart caths and I've talked with them extensively. I know all about it. No need to waste your time with that. Let's just make the arrangements and get this taken care of."

I said, "Even if you've heard about it, you don't really know the nature of the procedure and it will help you to know more about it. I need to tell you about it."

Mr. Smith looked at me, sort of shook his head slightly, and with a slight air of frustration, cheerfully repeated what I later realized was a prepared speech. His words came out even more quickly: "I guess you didn't understand. As I told you, I've become very informed about the procedure. I know about coronary artery disease. We don't need to go into all that. I've been through a lot. Tell me when and where and we'll get the thing done."

I recall—now 14 years later—just the briefest sense that there was a bit of a problem here. Mr. Smith was not responding appropriately. He was getting himself into a bad place, I thought, a place where he would be worse off if he didn't allow me to tell him about the procedure. It was my obligation to tell him about the procedure. But he didn't want me to.

After a few seconds—perhaps less—of "careful" reflection and internal struggle with this dilemma, I acted decisively.

I sat up a little taller, squared my shoulders (or at least did so mentally), took in a deep breath, firmed my jaw, and said:

"Mr. Smith, if you don't let me tell you about the test, THEN I'M NOT GOING TO DO IT! You need to let me tell you about it."

Silence. In retrospect I see Mr. Smith draw into himself and become a bit smaller in the chair. The conversation developed a much different character. Mr. Smith changed from hyperkinetic to subdued. His words came out clipped, his sentences short.

"Okay, tell me about it."
Feeling much better, I proceeded to tell him about coronary angiography. It was scheduled a few days later. He got through the procedure, was found to have coronary artery disease and had successful open heart surgery with a coronary artery bypass procedure.

I knew that something a bit strange had happened when Mr. Smith was in the office, but I didn’t understand it. Why was had our conversation suddenly gotten so tense? I didn’t think about it much more then, but, I have reflected on it many times since.

As Mr. Smith was recovering from surgery, I visited him regularly. We talked about many things and got to know each other very well. We talked about our backgrounds and our interests. We discovered we both were avid readers.

I also got to know Mr. Smith’s wife, who was constantly in attendance. She was supportive, warm, and concerned. We developed a good relationship. One day in the hospital, she and I were talking while Mr. Smith was busy with something else.

"You know," she said, "Mr. Smith is coming along very well. He really likes you. Your bedside manner is excellent and he is very pleased with your care."

I smiled and felt good.

Then she said something like this: "But he was really angry with you at first. He was terribly upset when you made him listen to your explanation about the cath procedure. He didn’t want you to do that. He came home so angry, he considered not going through surgery. We are so pleased that he did go ahead and that your relationship with him is going so well. We were concerned, but are delighted to find that you really do have a good bedside manner."

What a favor she did me. I think she meant it as a favor too. She wanted me to know that there was an area where I needed to change my behavior, that I had done something that they could now see was inconsistent with the rest of patient care philosophy.

I saw and spoke with Mr. Smith just the other day, 14 years after his surgery. He is doing well.

ANALYSIS OF CASE I:

In this interaction with Mr. Smith, the principle of beneficence guided me to do what the latest medical evidence suggested would yield the best outcome for him. I thought I could
best respect his autonomy by fostering a well-informed choice. I had little experience in situations in which there was an apparent conflict between these principles. When Mr. Smith declined more information, I thought that adherence to the principle of nonmaleficence required that I inform him. But, I did not significantly deliberate before advising Mr. Smith that he must listen to me, if I was to do the procedure. When he resisted my view of what should happen, I immediately exerted strong leverage on him to follow my wishes. We had no dialogue about how to deal with our difference of opinion. I did not explore other options with him. I took no moment to consider if I should change my course.

It is still embarrassing to realize how arrogant I was to exert that kind of pressure on Mr. Smith. It is to his credit that he was able to forgive me. Mr. Smith was a mature adult who had already decided that he did not wish to hear more about the cardiac catheterization procedure. I might have disagreed with his reasons, but he had made a specific decision which I should have respected unless I could convince him that there was a better route. I had developed a plan which I thought would best yield good outcomes for patients. When Mr. Smith had another plan, I was unable to alter my course and forced him to acquiesce.

I believe I was blindly driven by my subconscious need to maintain control in my relationship with Mr. Smith. He was a powerful person who took charge of our interaction. Whatever Mr. Smith's motives in asking me not to tell him about the procedure,
I could not allow it, because I would lose further control of the interaction. Seduced by my own needs, I delivered him a "knockout blow" in this struggle when I told him that he could either listen to my explanation or I would not do the procedure. In a cool moment, I am relatively confident that I would have behaved differently. But, I took no cool moment because I had become caught in the vortex of this subtle power battle. I was unable to distance myself enough from the situation to make a rational decision based on ethical principles. In the heat of this power struggle, I forgot that respect for autonomy indicated that I should value whatever position Mr. Smith assumed.

Since doctors have most of the power in the doctor-patient relationship, the use and abuse of power by physicians is always a central issue in their work. This case illustrates my abuse of power and demonstrates the importance of the moral virtue of humility for physicians. Humility blocks the seductiveness of power, setting the stage for one to use power appropriately in a relationship. Physicians with the virtue of humility are comfortable without power. They are not opposed to power, but they do not have strong subconscious drives to maintain control in human relationships. The virtue of humility, therefore, fosters physicians' rational deliberation about how physicians can best weigh the implications of bioethical principles. Since power is a constant feature in doctor-patient relationships, humility is an essential virtue for physicians.
CASE II:

A man with benign chest wall pain.

A muscular, frightened, thirty-odd year old police officer was afraid he was going to have a heart attack. He had recently developed recurrent chest pain. We talked about the pain, I found out something about him, and I examined him. I easily determined that the pain was not due to coronary artery disease, that he had no risk of a heart attack, and that he had a chest wall muscle strain, probably from weight lifting. I reassured him and sent him back to work.

ANALYSIS OF CASE II:

Many patients do not have physically serious problems, but the spiritual injury from such a problem can be crippling. Patients with such problems are often deeply frightened. When patients are frightened about something which the doctor determines is harmless, patients often experience a precipitous drop in their self-esteem. They often feel that they have wasted the physician's time, acted foolishly, exercised poor judgment, or behaved cowardly. They worry that the physician will think less of them. Since such patients may consequently become very spiritually distressed with very low self-esteem, they are extraordinarily vulnerable to injury by physicians. After making the benign medical diagnosis, therefore, the physicians' first step in healing such patients is to avoid further spiritual injury. The next step is to detect and to heal not only their original fear, but their subsequent spiritual morbidity.

The principle of beneficence clearly indicates that the physician's primary role in such cases is to make the correct diagnosis and to reassure the patient. Adherence to the principle
of nonmaleficence is particularly relevant because the patients are so vulnerable. But, what should be done to follow these bioethical principles in such a case? It may be difficult to detect such a patient's distress. An essential prerequisite for a physician's sensitivity to such distress is the physician's acceptance of the patient's fears and other spiritual sufferings as legitimate objects of attention. If a physician believes that a patient's distress is cowardly, the physician may regard the patient's distress with contempt. A physician's contemptuous reaction may cause further spiritual injury to that patient. In contrast, what the good physician must do is to show such patients that their concerns are fully worthy of the physician's time. This outcome requires the virtue of humility. Humility is important in at least two ways. First, it prevents arrogance. Arrogance keeps physicians from accepting such patients' fears as legitimate. Arrogant physician responses are likely to demean such patients. In contrast, humility is a virtue which disposes physicians to accept patients' frailties and imperfections. Humble physicians will accept patients' fears as legitimate even if the physician would not have such fears or if the patient is cowardly. Humility is, therefore, the means of the first phase of healing such patients' spirits: accepting their states of distress as legitimate objects of medical attention.

In such situations, humility thus lays the groundwork for the second essential virtue of physicians: compassion. Physicians with compassion feel patients' suffering as if it were their own and
respond in ways that are intended to relieve or improve the patient’s suffering. For physicians to feel others' suffering as their own, they must believe that the suffering is a legitimate problem. Compassion is the means of a second critical phase in the reassurance of such patients. Even though the virtue of humility prevents the arrogance that would motivate a physician to ignore such patients’ suffering, the suffering itself must then be identified and then the suffering must be acted upon. Compassion is the means of both relationships to suffering. Without compassion, subtle forms of suffering will not be detected. Without compassion, the physician is not motivated to take the considerable time and effort it may take to reassure such patients. Compassion is the means of detecting patients’ suffering and of responding to it. In such cases, therefore, the detections of patients’ spiritual problems and adequate responses to these problems are only possible through these virtues. The virtues also prevent inappropriate responses.

CASE III

I advise the patient to have a procedure which I will perform (this is a hypothetical case which is like many I have encountered).

A fifty year old logger is referred to me by his family doctor for cardiac catheterization because it appears that he may have threatening coronary artery disease. For two months he has had increasing chest pain with exercise or stress and a very abnormal electrocardiogram during a treadmill exercise test. His father died at age sixty of a heart attack. He does not usually go to doctors, but he has reached the point that he is unable to continue working because he gets so much chest pain, despite medication prescribed a month before. His physician advised him to see me a month ago, but he declined. I review his story, examine him and study the
results of his previous tests. I then meet with him and his wife to make my recommendations.

I tell him that I agree with his family doctor's opinion that he likely has serious coronary artery obstruction. I sketch alternatives, but advise him to have the catheterization, because the course of his pain suggests that he likely has a tightly obstructed coronary artery which may either cause a devastating heart attack or death when it occludes. I do the cardiac catheterization procedure, injecting dye into his coronary arteries. It shows significant obstructions in his coronary arteries. I again note alternatives, including cardiac surgery, but advise him to have coronary angioplasty, a balloon procedure to dilate open the arteries. I do the procedure.

ANALYSIS OF CASE III:

In order to analyze the roles of principles and virtues in this case, I must first explain objectives of informed consent which shape the obligations physicians must meet when they are advising patients. I must then set out a number of factors which influence physicians' advice to patients in such circumstances.

The goal of informed consent is that competent patients should make voluntary, informed choices of what treatment or diagnostic course, if any, they will agree to pursue. Physicians, therefore, must tell patients what are generally accepted as reasonable choices for patients' particular problems, including the nature and likelihood of potential benefits and harms of those choices. The physician should also recommend a specific choice, if it is thought best for the patient, but also should lay out the other choices for the patient in a fashion which does not coerce the patient toward the physician's choice, since the physician is obligated to respect the patient's privilege of choosing another course.
The bioethics literature, and the courts, through tort litigation, have affirmed that the physician's respect for the patient's autonomy should override the physician's allegiance to the principle of beneficence in the informed consent process. That is, the physician's primary obligation in this process is to foster the patient's rational, free choices, despite what the physician thinks is the best choice for the patient. This goal, then, obviously requires that the choices and recommendations that physicians make to patients should be as free as possible from influences which bias physicians toward one choice or choices, more than some others."

This goal of informed consent is a particularly difficult one for physicians who advise patients to have procedures which those physicians will also perform. These physicians are enmeshed in a complex web of conflicts of interest which entice them to recommend the procedures that they perform. Cardiac catheterization and angioplasty, in my view and in my direct experience, are excellent examples of such conflicts of interest. The following are some of the reasons physicians are inclined to recommend these procedures. Performance of procedures like cardiac catheterization is financially very rewarding. Performance of large numbers of procedures maintains or improves the physician's technical competence. Performance of procedures requested by referring physicians maintains a solid "referral relationship" with the primary physician."

If I often do not do a catheterization when referring physicians want patients to have them, after a time these
physicians will probably send their patients to another specialist and my practice will decline. My self-image as a modern cardiologist, tied both to my technical competence and to the performance of procedures, is also reinforced by doing the procedures. Just as I would feel like a carpenter only when using hammer, saw and other tools of my craft, I feel like a modern cardiologist only when I am doing catheterizations and angioplasties. I am also likely driven to be heroic. It does not take great imagination to see that use of a cardiac catheter or angioplasty balloon is symbolically equivalent to wielding a weapon which kills the enemy, coronary artery disease. There are other sources of physicians' conflicts of interests, but these examples suffice to illustrate that physicians have many strong influences which bias them to recommend procedures which they perform.

There is no problem in determining the implications of the principles of beneficence and respect for autonomy in the informed consent process for patients such as the one in Case III. The problem is to find ways to minimize the conflicts of interests of such physicians and their consequent bias toward advising patients to undergo procedures which they perform. Although these conflicts of interests cannot be totally eliminated, I believe that it is only virtues which can mitigate the force of these conflicts.

Physicians with the virtue of justice will be disposed to reject their own economic gain as a motive for advising a procedure. Just physicians are motivated to be fair. Since it would be unfair to advise a procedure to a patient when the primary
motive is greater income for the physician, just physicians will be quite careful to favor the interest of the patient. But, such just physicians would first have to recognize their susceptibility to conflicts of interest. The virtue of humility is necessary for this outcome. Humble physicians know that they are vulnerable to conflicts of interest because they do not assume that their good intentions eliminate their susceptibility to conflicts of interests. Humble physicians will, therefore, be disposed to help patients get other opinions, because they understand the difficulties of giving unbiased advice. The virtue of humility also fosters the objectives of informed consent by blocking physicians' corruption by power, as discussed in Case I. Humility also blunts physicians' ego needs to be heroic. Humble physicians are comfortable with themselves without needing to perform acts that are symbolically heroic acts. Physicians with courage will be able to accept the possibility of reduced referrals from a referring doctor, if a procedure is not medically indicated.

I am not suggesting that physicians in such circumstances will be able to give unbiased advice to patients. The nature of conflicts of interests is such that persons are susceptible to their influence, no matter how motivated the persons are to do what is right. Yet, for the reasons cited above, I argue that the force of these entities to bias physicians can be mitigated by these virtues.
CASE IV:

An elderly man seen in the emergency department.

This troubled man has just been yanked from one location to another. He had been flown by helicopter from another community. In his middle seventies, he is anxious, sick, sick of being sick, frustrated. He is agitated, restless, worried. From my experience, I expect much of this before I meet him.

He just left another hospital after a week and feels no better. He's been having recurrent nausea and intermittent abdominal and lower chest pain. In the other hospital he was diagnosed to have congestive heart failure, treated for the associated excess fluid accumulation, and sent home on a large number of pills.

I greet him as he is rolled by his competent nurses into the emergency department on a stretcher, with containers of intravenous fluids hanging, oxygen and electrocardiographic monitor attached. He is restless. Very restless. In another room a baby is crying, crying loudly, keeps crying! As the nurses come and go, I'm trying to keep the curtain closed because the room looks out onto the entrance of the emergency department. This is one of many steps by me to maintain his dignity and restore his psyche to some semblance of its usual state as we, he and I, try to move on with the job.

I'm attempting to get his story, but the patient jumps all over the lot. I'm trying hard to be nondirective, an approach I usually find very helpful and therapeutic, but I eventually must keep him focused on issues related to his central complaint, as he is so anxious to get out all relevant information--afraid that his problem will again not be solved--that he throws out symptoms, experiences, hypotheses, and worries like baseballs in a batting cage, the pitching arm releasing anywhere in a 360 degree arch at varying speeds.

I sit when I can, take his pulse off and on, pat his back, his arm or his leg, and try to project competence, caring, and a centering calmness. I want him to be drawn in by my calmness, I want it to envelop him in a way that makes all the commotion peripheral. I want him to know that I care about him and his story; I want him to feel these qualities in me. I try to keep him focused on me, trying to keep all the hustle and bustle of the emergency department on the periphery of his attention.

The nurses come and go, taking blood pressures and making adjustments, checking to see what might be needed. The patient is more comfortable sitting up. He has to lie back down to have blood drawn. He sits up. I start taking notes--this is not a case I'll be able to remember

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without them. I’ll have to sort out the puzzle pieces when there is less disturbance. Suddenly something is running into me through the curtain. It is M-, the x-ray technician, who is trying to take the other patient in the room out for his chest film. He apologizes, I smile and say "No problem." Later M- brings in the portable machine and takes a chest x-ray on the man I’m seeing.

This patient also has chronic lung disease and is ill. I’m trying to decide how ill he is so that we can determine in what unit he should be placed. I ask B-, the respiratory technician, to draw a blood gas to assess his arterial blood oxygen, carbon dioxide, and acid content. The nurses come and go, taking the patient’s blood pressure. Later I invite in some friends of the patient so he can make connection with them, so they can give him some security, some sense of support through all the chaos. A bit later his wife arrives and she stays while I continue to try to get his story and move us both through what has to be done. I get beeped two or three times during the interview and each time have to make a phone call or two. Fortunately, I have switched to a vibrating beeper, so there is no noise further disrupting this scene. As I go out to the phone, I occasionally hear the radio relaying transmissions from emergency crews out in the field.

One of my calls is from a woman eighty miles away who wants an explanation or reassurance that her problem couldn’t be cardiac, although her doctors have advised her that she should have some cardiac tests. It takes me awhile to figure out the source of her concern. I give her some advice. The baby is crying louder. I go back in to see the patient. The nurses come and go. They are old friends. Intermittently I think of things and ask the nurses to get them done. As usual, they cheerfully carry them out or make other suggestions. I ask if we can start an IV. The nurse smiles and points out that the patient has one. I look down and I have my hand on the patient’s arm around the IV tubing. I think, "what the hell!," and grin sheepishly.

Meanwhile the patient is getting out his story. I start to get the general picture and think of various possible diagnoses, which generate new questions. He is also starting to relax and getting more intellectually focused in the process.

We have no lab from the other hospital. I ask the emergency department clerk to have it telecopied. Soon she comes in and says they did no lab. I say, "He was just in the hospital for a week, he must have had some lab. Please call them back." She does. The telecopy never comes.

I start examining him. Eventually I get everything done except a rectal exam. I am called out. I come back
and the nurses have him ready to go upstairs. He goes upstairs. I do a couple of other things and then go his room, talk some more, and do the rectal exam. By this time he is considerably better. His hyperventilation (which had been evident from his arterial blood gases) has stopped, he is relaxed, he sees that he is going to get some attention. In fact, he has already gotten some attention, care, tests, and support which have their therapeutic effect. I sit down and write a long list of orders, get called back to the emergency department to see another patient, then go back to his section and dictate a history and physical exam. I write a progress note. I again review the orders. I tell him good night, tell him who will be seeing him the next day, shake his hand and give his arm a squeeze.

ANALYSIS OF CASE IV:

This elderly gentleman had been ill for several weeks, had a sudden exacerbation of his symptoms, a trip to one emergency department, and a helicopter ride to another hospital. In the emergency department he had interacted with several people and underwent several procedures. It was a chaotic, stressful experience, exacerbated by his semi-nakedness in the usual hospital garb of a backless shift, his confinement to a stretcher, and his attachments to a nasal oxygen line, and lines delivering intravenous solutions.

Illness and the psychological trauma of such an experience rapidly reduce persons' sense of control and the severe emotional impact impairs their ability to think clearly and logically. The patient was competent, but his personal autonomy was markedly reduced. Physicians with any practice experience are aware that patients' autonomy is impaired in these circumstances. Seasoned practitioners know how profound this impairment can be. Physicians who adhere to the principle of respect for patients' autonomy, and
who understand what happens to patients' psychodynamics in such circumstances, will study how to support and restore patients' decision-making capacities and be alert to ways to prevent further decline in their capacities.

The principle of beneficence requires that, as usual, our efforts be intended to heal, improve, or palliate this man's problems, depending on their amenability to treatment, and to comfort and support him. These goals are partly achieved through the approaches of me and the nurses that allow us to exercise our technical competence. It was also essential that I had the virtue of patience for adequate medical evaluation and treatment of this man. Interruptions, his emotional state, and the nature of his illness prolonged my evaluation. If I had not obtained his story, I could not have developed an adequate initial diagnosis and treatment plan. Impatience might have affected my transaction with the patient in ways that restricted and altered his story. It took time for him to get out his story and at first I had to let him get it out in his own way. If I had pressed him to tell his story more quickly, he might have left out essential parts of the story. My strategy, as it always is, was to approach him first with the least framework possible. He is then able to tell whatever he thinks is important and I might learn important things that I would not have asked about. Patience is also very important in therapy. If patients are to be treated as people, not just as objects, then they must have the opportunity to tell what they think is important. If they are treated as people, their dignity and self-
respect is shored up, which helps healing. An early part of therapy is therefore being a good listener and that requires patience.

I have not always been as patient as I was on that occasion, nor have I been so aware of the necessity for it, nor am I now always adequately patient. The patience I do have has been improved by reflection on my successes and failures in repeated attempts at the virtue. Human interaction is so complex that one can continue to refine a disposition like patience throughout a professional life. But patience is not enough. This encounter also required that I have the virtue of perseverance.

Patience is easily undermined if it is not supported by perseverance. I had to keep my attention focused despite distractions and disturbances which might have tempted me to do an incomplete job. One must keep at the work until an adequate evaluation has been obtained. That effort takes perseverance. But perseverance without patience may be misguided. This man slowly gave his story in disorderly fragments which I had to order and to integrate. If I had rushed his effort, I would have limited the information or altered its content. Perseverance helps me continue until the job is done, patience restrains and guides my perseverance into the best channels. But patience and perseverance are not enough either. I also needed the virtue of equanimity, a calmness that contrasted with the troubled sea of this patient's emotions.
Equanimity was therapeutic for this patient. He suffered a series of emotionally traumatic experiences before and after he came to the emergency department. Most of us would have problems maintaining our intellectual and emotional integration after such an onslaught of events. Physicians' equanimity centers patients' attention and calms their emotions through facial expression, slow movement, body position, caring touch, modulated voice tone and measured speech. Equanimity also benefits physicians themselves. Equanimity is a disposition which reflects inward and outward."

Like the patient, I was also bombarded by events in the emergency room and by the incoherent bits of history told by this patient. Equanimity allowed me to remain centered on the primary task and avoid anger or irritability that would impair my care of this patient. Equanimity supports patience and perseverance. Patience is harder without the firm foundation provided by equanimity. Less patience is required when it is supported by calmness. Equanimity reduces other potential stresses that require more perseverance.

The virtue of justice is also important in this case in a way that is important in all cases. This man would have been treated unjustly if he had been discriminated against and received inferior evaluation, treatment, attention or accommodations. Laws protect him against this, of course, but there are many forms of discrimination which cannot be prevented by laws. It would not be practical to develop a complex series of action-guides to cover all potential sources of injustice. In this kind of circumstance, what may be most helpful is cultivation of a virtue, justice, that
corresponds to the "fundamental obligation" of the principle of justice. Justice would then be the disposition to act justly, with practical wisdom working out the nuances of confusing cases.

This case thus illustrates the importance of virtues in a routine medical circumstance which does not appear problematic from the perspective of principles. It is easy to determine what is generally indicated by the principles of beneficence, respect for autonomy, etc. My discussion shows, however, that there are several virtues which are essential for this man’s care. His care required medical-scientific competence, to be sure, but imagine what his care would have been, for example, if I had not had the patience to listen to his story and the equanimity to calm his distress.

CASE V:

A man with a chronic, progressive illness.

I care for a seventy-five year old retired man with advanced and progressive valvular and coronary heart disease. Despite the best possible medical management he is getting worse. He loves to exercise, but must cut down his activity because of breathlessness and chest pain. He is not a candidate for correction by open heart surgery and he is on the best possible medications for his condition. It is clear to him and me that his outlook is getting worse.

I see him at my office every two to four months. We talk about his condition and I make minor medication adjustments. I express my interest and concern. I am cheerful and supporting.

ANALYSIS OF CASE V:

This man’s situation has counterparts in the later periods of many chronic diseases. Medical science can retard the progression of his disease, but eventually has declining success. He will go
through a long period of adjustment to his loss of capabilities and eventually to his terminal status.

From the view of principles, I have some clear obligations to this unfortunate man. The principle of beneficence indicates that the patient needs continued care and comfort to the best of the my ability. Not only should I deliver my own medical care, but I should work with other services to obtain home nursing care and, ultimately, the help of Hospice to assist him in his final days. The principle of respect for autonomy indicates that I should have a dialogue with him about the costs and benefits of life support and cardiopulmonary resuscitation. I would then encourage him to discuss his wishes with his family and with me. The principle of nonmaleficence is served if I avoid harmful procedures and potentially toxic drugs and dosages that have little possibility of helping him. I should not abandon him physically or emotionally. The principle of justice indicates that it would be unfair for me to transfer his care to someone else because I am paid less for caring for patients with chronic, compared to acute illnesses. But, his care will be inadequate without the virtues.

This man needs palliation of his suffering through the virtues of care, compassion, patience, perseverance and other dispositions that will comfort and support him through his illness. He needed these virtues in me before this stage in his illness, but then medical science also offered more. Chronic illnesses are often emotionally traumatic and progressively disabling. Such patients become isolated and sometimes alienated from friends and
acquaintances. Such patients' self-esteem may be impaired and they may become emotionally unstable. They have despair. They may suffer from pain, breathlessness, or other physical impairment.

Relationships of physicians with chronically ill patients contain many moments in which expressions of care palliate their suffering, support their struggle, and maintain their dignity. These virtuous acts are fueled and informed by the virtue of compassion. It is the act of feeling his plight as if it were my own, an essential component of compassion, which helps me understand this patient's needs and impels me to respond with the other virtues. Compassion informs me of his suffering and motivates me to relieve it.

CASE VI:

An early morning call about a woman with chest pain.

It's two o'clock on a Sunday morning. I am asleep. I've been "on call" for the cardiology service since six the evening before and will stay "on call" until about seven in the morning.

The phone rings. From long habit, I roll over on my right side and in one motion reach out for it with my left hand, trying to pick up the phone before it rings a second time and possibly awaken Janet, although for years she has slept through most of my phone calls.

I get it before the second ring and start relaxing. I am reasonably awake by the time the phone gets to my ear.

"Hi John, this is Trish (nurse on the cardiac unit where patients often have their heart rhythms monitored, but who don't need to be in the intensive care unit). Sorry to bother you, but there is a woman here who is having chest pain. Do you know Mrs. B, Stan's (one of my cardiology colleagues) patient?"

"I'm sorry, I don't, Trish."

"She's 75 years old and was admitted (to the hospital) with unstable angina (increasing chest pain due to reduced blood flow through the coronary arteries to the heart muscle). Stan "cathed" her (did coronary angiography: injection of dye into the coronary arteries}
through a catheter introduced from the artery in the groin. She has severe obstruction in the right coronary artery and the left anterior descending, and Stan advised that she have bypass surgery. Jim (a heart surgeon) saw her and she is on the open heart surgery schedule for Tuesday. Her cath was Thursday and she’s been stable until about thirty minutes ago, when she began having chest pain. I’ve given her two sublingual nitroglycerin pills (rapid acting nitroglycerin absorbed through the veins under the tongue, which often provide rapid relief of angina—heart muscle pain due to inadequate oxygen supply to the heart muscle) without relief. Her pain is not severe, but it isn’t going away. Her electrocardiogram is unchanged (it could show changes indicating severe reduction in the heart muscle blood supply or even a heart attack). She’s not in a lot of distress, but the pain has continued. Her blood pressure has dropped to 90 (a mild drop due to the nitroglycerin, not unusual, especially in the elderly)."

I reply: "So we’ve got an elderly woman whose coronary anatomy suggests a very fragile circumstance (two of her three main coronary arteries are seriously occluded and she’s having continued pain—routine anginal pains only last a few minutes, so Trish and I are worried that she has occluded one of her coronary arteries and is threatening to have a major heart attack). Okay, let’s do this: give her 250 milliliters of normal saline (intravenously) to get her pressure back up, start an intravenous nitroglycerin drip, get another electrocardiogram, and give her 2.5 milligrams of intravenous Valium (sedation to help her relax as the patient is surely frightened, which may also be aggravating the chest pain). Call me back in fifteen minutes. If she’s no better, I’m coming in."

I lie there in bed considering the circumstances. At least I have another fifteen minutes of sleep before I have to go to the hospital. But I don’t go back to sleep. I think about how fragile this woman’s health is. At age 75, she will have poor tolerance of much of a cardiac insult (heart muscle injury from a heart attack) and something has suddenly occurred after two quiet days. I don’t want to get out of bed. I’ve never wanted to get out of bed in the middle of the night. But I don’t go back to sleep. By the time Trish calls back, I am putting on my clothes, deciding that I should see the patient whether her pain goes away or not.

"John, her pain is not improved. She’s not in a lot of distress, but it’s still there."

So I drive to the hospital and I’m there in a few minutes. I quickly look over her hospital chart and review her electrocardiograms before I see her. I’ve never met this woman, so as I introduce myself, give her
a friendly handshake, express my regrets that she's having problems and sit on the side of her bed. I quickly confirm the story of her pain and examine her heart. I find nothing that Trish didn't already identify. The patient is not in any trouble, but her chest pain is not going away.

I conclude that she may have a life threatening heart attack or she continues to have chest pain. I explain to her that she is in no trouble at the moment, but that her continued pain is of concern. I advise her that I should take her to the cardiac catheterization laboratory and place an intra-aortic balloon pump in her aorta (A "balloon-pump" is a long tube with about a foot-long balloon around the upper end, inserted through the femoral artery in the groin. When connected to a sophisticated pump, the balloon fills and empties with helium in concert with every heart beat in a way that reduces the work of her heart pumping and improves blood flow through the coronary arteries). I explain to her that this balloon pump will reduce the risk of a heart attack and help stabilize her until surgery, although it has a small, but definite possibility of serious or even fatal complications. As we talk, I sit on the end of her bed and give her a warm, sympathetic smile and intermittently slightly squeeze or pat her calf through the bed covers to communicate my caring and support. She doesn't deliberate at any length and agrees to proceed.

We call in the cath lab crew. As they are coming, I call her husband who is staying in the hospital's "support housing" for patients' friends and relatives. I tell him what we're doing and why. We had sent the security guard to wake him. We take her to the heart catheterization laboratory and place the balloon pump without complications or serious discomfort for her. Her pain stops about the time we place the balloon. I call Jim, the heart surgeon, to notify him of this development. He advises that if she remains stable, he will review her status in a few hours on morning rounds. I go out of the intensive care unit and talk to her husband and daughter, explaining what we've done, her prognosis, and what our plans are. (She remained stable through the night and had successful bypass surgery the next day.)

I drive home about four-thirty in the morning. As usual, it takes me about thirty minutes to go back to sleep. I sleep until ten that morning and start the other work I had planned to start about seven.

ANALYSIS OF CASE VI:
The principle of beneficence is the ethical principle of primary importance in this case. Her good obviously requires that I go to the hospital and assess her problem. I could not have adequately evaluated her by phone, although hospitalized patients' problems can often be assessed sufficiently by a telephone discussion with the nurse. The patient would probably be satisfied with pain relief, but I know that pain relief is not sufficient, as the pain may be the harbinger of a disaster.

The principle of beneficence will always indicate that I should advise her to follow the course which I think would lead to the best outcome for her problem. Of course, she might prefer some other course, such as avoiding the balloon pump. The principle of respect for autonomy indicates that I must explain the procedure, give her the opportunity to ask questions about it, and allow her to decline it. But, her autonomy is impaired because she is ill, tired, and fearful. She has already consented to cardiac surgery, a much more risky procedure than insertion of a balloon pump, and the latter will reduce her risk of surgery, now that she has again become unstable. I know, from experience with many similar patients, that she is unlikely to disagree with my advice, even though she doesn't know me and I do not coerce her to agree. The cascade of events push her to accept my advice at this point, as it fits into the scheme which she has already accepted.

The principle of beneficence further indicates, of course, that I should reduce her physical and spiritual suffering. An experience like this is obviously very stressful. She is already
in the hospital and waiting for open heart surgery, a frightening thing to anticipate and from which there will be a long and painful recovery. She knows that her risk of dying from the surgery is higher than that of younger patients. She is having this chest-pain problem when her family is not there, when she is away from her home town, and when she has a strange doctor advising her. Thus, this woman, who has a simple problem from the medical point of view, has a very complex problem from a broader view of the physical and psychosocial dimensions of illness. When one appreciates the broad implications of this encounter in the early morning, one understands that adherence to the principle of beneficence requires that I attend to many issues simultaneously. My central task is to determine if she is at risk of a heart attack, and then to perform the balloon pump insertion to try to prevent a heart attack, but there is much more to be done in caring for her, and that requires the virtues.

Getting out of bed is of crucial significance in fulfilling my obligations to this patient. Do I get up and come to the hospital or do I not? If I do not, I do not fulfill my obligations to this patient, but there are temptations not to get up. Getting out of bed at 3 A.M. is dependent on the virtues of courage and honesty. I am not being melodramatic when I assert that courage is required to accept the potential discomfort of sleep loss. It is often hard work to get out of bed and come to the hospital. I would almost always rather be doing something else, namely sleeping, as I know the cost of getting up and it gets worse as I get older. My body
and mind complain the next day or days. If the physical and emotional costs are excessive, I should do something different in my life, but that night, at 3 A.M., when I am the one responsible, I needed to go to the hospital. There is nothing extraordinary in my actions that early morning. I did what physicians routinely do. Courage sets the stage for me to do an honest appraisal of her problem. What treatment does it need? Do I need to go to the hospital, or not? Without the courage to face the consequences of my honest appraisal, I may be tempted into intellectual dishonesty.

This woman and I were strangers meeting under very stressful circumstances for her. She was tired and frightened. It was essential that I have compassion with which to feel her distress and to respond to it. If I have compassion, I feel her suffering as if it were my own and I respond to reduce her suffering.

* * *

The analyses of these six cases demonstrate that although physicians must respect bioethical principles, the virtues are essential for physicians to meet their obligations to patients. The importance of the virtues in their own right, and in comparison to principles, is discussed in the next chapter.
NOTES


4. See my discussion in Chapter Four of the two bases for the derivation of virtues.


6. Maintenance of control, a power issue, may have also been the reason that Mr. Smith wanted no further information, but there are other possible reasons. For example, I now know that there are some patients who know that they get very anxious if they learn too much about what a procedure will involve. People vary and physicians need to understand that they may not understand their patients completely.

7. This case illustrates what Jay Katz is talking about in The Silent World of Doctor and Patient (New York: The Free Press, 1984). See his Chapter VII: "Acknowledging Uncertainty: The Confrontation of Knowledge and Ignorance." Katz believes that informed consent is a facade unless physicians become much more aware of their unconscious needs for control over patients and over uncertainty. These needs influence their advice to patients and prompt them to control encounters with patients.

8. This case makes a strong argument for the importance of the virtue of humility in doctors. Humility sets the stage for the reflective self-consciousness and intensive study of the doctor-patient relationship that Katz urges. See Katz, The Silent World, 151-152, 226.

9. There is an extensive literature in informed consent. See, for example, Beauchamp and Childress, 74-119.

10. When I refer to bias, I am using the conventional usage, which I understand to mean that bias is a preference for something based upon factors other than the merits of the thing itself.

11. A "referral relationship" has two components germane to this discussion. First, there is, in fact, a relationship between the referring doctor and consulting doctor. They know each other, have communicated about patients, etc. The second component is the inclination of the referring doctor to refer patients to the specialist.

13. Humble physicians can still be heroic if circumstances demand.


CHAPTER THREE

Arguments That Virtues are Essential

The evidence presented about the history of the virtues in medicine shows that, from the time of Hippocrates until recently, the virtues had been considered important for physicians. Scribonius Largus, of the First century, A.D., and John Gregory, of the Eighteenth century (1724-1773), were two physicians who thought that it was important to develop a set of physicians' virtues. Gregory took pains to justify his proposals philosophically. But, a turn away from virtues was evident only three decades after Gregory's death, when Percival's *Medical Ethics* appeared. In contrast to Gregory's scheme, which emphasized virtues, Percival stressed attitudes and actions that would enhance the power and status of physicians. This move away from virtues was very evident by 1847, when the American Medical Association published its first code of ethics. The document was filled with Percival's concepts. The ensuing century and a half has seen a continued move away from explicit teaching of virtues to novice physicians. This decline in virtue emphasis is mirrored in modern bioethical literature, which has almost exclusively focused on implications of ethical principles.

These trends may explain some paradoxes in present medical education. Medical school curricula, to my knowledge,
contain little or no formal place for teaching virtues, but there is good evidence that some virtues are valued and taught by medical faculty. For example, Charles Bosk showed that the faculty of a prominent surgery program highly valued the virtue of honesty in their trainees. My own experience demonstrated the strong emphasis on the virtues of diligence, honesty, conscientiousness, perseverance, and courage in a leading medical institution. Although it is good that some virtues are being taught, the absence of any formal place for virtues in curricula probably reflects lack of dialog about the virtues among medical faculty.

The absence of dialog about virtues among faculty and students prevents their mutual critical examination of the virtues. The lack of critical examination prevents seeking answers to questions like the following. (1) What virtues are being taught? (2) Are the faculty teaching all the virtues that they should? (3) What is the best conception of each virtue? (4) Are trainees being assisted in reflecting on the virtues which they are trying to achieve? (5) Are any vices being taught? The scarcity of efforts to answer such questions may explain why virtues like compassion and care are uncommonly taught and why some vices are being taught. As highlighted by Melvin Konner's recent polemic about the medical school experience, medical students and residents have difficulty developing care and compassion for their patients because they are so "brutalized" by the pressures to
which they are subjected. In my experience about twenty years before, some students and many residents were pushed to the point of illness or psychological dysfunction. Many of my colleagues have also recounted instances in which they were harassed by superiors. The medical education system, instead of teaching compassion and care, instead promotes vices like indifference to patients' suffering, neglectfulness of patients' needs, and relative intolerance of students' personal needs. Physicians are then expected to treat their patients humanely, when they have been treated inhumanely in training! An example of these aberrations is seen in the excessive emphasis on hard work in training programs. This skewed emphasis contributes to the vice of "workaholism" that harms so many physicians and their families.

Whatever the status of virtues in medical education, my analyses of the six medical case histories provide strong evidence that the virtues are essential for physicians' medical practices. The analyses of cases I, II, and III, for example, demonstrate three different ways in which the virtue of humility is crucial for physicians. The analysis of Case I suggested that the virtue of humility may prevent physicians' from being tempted to exert control over patients for the sake of control. Case II demonstrates that the virtue of humility may sometimes be necessary before the physician can perceive what is necessary to heal some patients. The analysis of Case III argues that the virtue of humility can
prevent inappropriate outcomes of physicians' drives to be heroic and powerful.

These demonstrations of the essential nature of the virtue of humility will allow me to make the first of several conclusions I want to draw about the special contributions that virtues make in medical practice. But, to demonstrate the significance of these contributions, I must first note basic differences between principle-based and virtue-based approaches to morality. The assumption of principle-based morality is that moral agents determine their obligations by conscious, rational deliberation, which weighs the implications of the principles. The outcome of this moral calculus is "action-guides," which indicate the action one should take in the instant case. In contrast, moral deliberation has only a minor role in the virtue-based approach to ordinary cases. Virtuous responses are "instinctive," or habitual, although the responses are monitored and occasionally modified by practical wisdom.

The distinction between these two approaches to morality allows the demonstration of the first major contribution of virtues. Possession of the virtues fosters physicians' sensitivity to their obligations in some cases. For example, the police officer in Case II had no disease, but suffered from fear. I argued that compassion was essential for sensing and responding to the patient's fear. I also argued that humility lays the ground for the physician to accept the
patient's fear as a legitimate object of compassion. In other words, humility set the stage to detect the patient's fear, while compassion was responsible for detecting and responding to the fear.

The importance of the virtues, in contrast to the principles in this case, is shown by assessing the applicability of action-guides. If an action-guide could be devised by which physicians could fulfill this obligation to such a patient, then the virtues would be unnecessary. In fact, there is no action-guide which would suffice here. From the detection of the problem, to the reassurance of the patient, the entire effort in Case II occurred through the interaction of the virtues of humility and compassion with clinical judgment. No moral deliberation was necessary. My point here is not to diminish the importance of principles, but to establish that the moral virtues are essential for detecting and responding to patients' medical problems.

Analysis of Case I illustrates a somewhat different relationship between the virtues-based and the principles-based approaches. This case required that a judgment be made about the relative importance of the principles of beneficence and respect for autonomy. This was a case where some moral calculus was needed, but it was the lack of a virtue, humility, which prevented satisfactory deliberation. It was a case involving informed consent. My error, the decision to take a strongly paternalistic approach, arose not from
difficulty in interpreting the implications of the principles, but from my response to a power struggle between me and the patient. Power is a very important issue in doctor-patient relationships because doctors have so much power and patients usually have so little. Power tempts people to exert control, a temptation to which physicians are not immune. If physicians are seduced by power, the power, rather than the good of the patient, may become an end in the doctor-patient relationship. Physicians, therefore, must have the means of opposing the temptations of power. That means is the virtue of humility.

The principle of respect for autonomy indicates that physicians should lay out all reasonable alternatives for patients. The analysis of Case III demonstrates that physicians often have conflicts of interest which strongly bias them to advise procedures which they can perform. The discussion showed that the virtues of justice, honesty, and humility are essential to counterbalance factors that bias such physicians to advise procedures. Just as in Case I, in Case III the virtues set the stage for good moral deliberation. The principles are essential, but so are the virtues.

Case IV illustrates another crucial role of the virtues. In this case, patience, perseverance, and equanimity allowed the physician to carry out the objectives indicated by the principles. The virtues were the necessary instruments for
providing adequate care to this patient in service of the principles.\textsuperscript{12}

Case IV demonstrates that possession of the virtue of equanimity may enhance physician's efforts to heal the patient. The physician with equanimity radiates calmness to the patient, thus aiding the patient's healing. Physicians cannot use any ethical principle directly to foster healing. From the principle of beneficence, one could easily derive the action-guide that one ought to act with equanimity and that one ought to foster healing. But, the conclusion that one ought to have equanimity does not establish equanimity in oneself. Equanimity is not an action, it is a character trait which shows itself in chaotic circumstances, like those in Case IV. One cannot simply decide to be calm. One can only be calm in such circumstances if one has developed the habit of being calm. The need for the virtue of equanimity, but not the virtue of equanimity itself, is derivable from the principle of beneficence. The same argument applies for the general relationship between principles and virtues. Principles may indicate the need for a virtue, but the virtue itself is not derivable from the principles.

There is one other important difference between a principles and a virtue approach. It is easy to show that the principle of beneficence indicates that physicians should have humility, for example. But, the motivation to be humble cannot be derived from this principle. In contrast,
motivation is a part of the virtue itself. When the virtue of humility is developed in a person, the person is humble. The virtue of humility and the motivation to be humble are inseparable.

Consider the importance of the virtue of justice in Case III. Just physicians resist biases to advise procedures in such cases. The motivation to be just, analogous to the motivation for humility, is not derivable from the principle of justice. In contrast, if one has the virtue of justice, one is just—motivation is an inherent part of the virtue. One cannot have the virtue of justice without being motivated to be just.

Case II showed the importance of compassion. Compassion has two components and motivation is a feature of both. The first component is the disposition to feel the other's suffering as one's own. The "disposition to feel" includes the motivation to feel the other's suffering. The second component of compassion is the disposition to respond to the suffering. The "disposition to respond" also includes motivation to have a compassionate response. In contrast, the principle of beneficence indicates that physicians should be compassionate, but this principle does not yield the motivation to be compassionate. Analysis of Case VI demonstrates the relevance of motivation for care of the chronically ill. In contrast to the patient with obvious suffering from an acute medical problem, patients with chronic
illness often have suffering that may not move persons without compassion. A physician working from action-guides will probably identify and be moved to respond to the first patient, but the less significant suffering of the latter patient is much less motivating and this physician may not have a compassionate response. The motivation of a physician with compassion, however, is not determined by the extent of the other’s suffering. Instead, the person with compassion is always motivated, and will respond as indicated by the type and degree of suffering."

A last example of the importance of the motivation intrinsic to virtues will be drawn from Case VI. The principle of beneficence obviously indicates that the physician must get out of bed and go in to see the patient. Experienced physicians are very familiar with the personal discomfort or distress that often ensues from their nocturnal forays. Yet they must get up. The duress of getting up tempts physicians to deny the significance, or potential significance, of patients’ nocturnal problems. In such a case, motivation is obviously critical for a proper response. Without the virtues, many night cases do not have enough incentives or disincentives to motivate physicians adequately."
In summary, the history of the virtues in medicine suggests that the virtues may have always been essential in physicians' practices. Although virtues do not seem to have a formal place in medical school curricula, some virtues are being taught. Unfortunately, some vices are also being taught.

The analyses of the cases provide strong evidence that virtues are essential for physicians' practices. In comparison to ethical principles, virtues also have essential, but different, roles in medicine. Virtues are needed in some cases to sensitize physicians to patients' needs and for physicians to respond to the needs of patients in some cases. In other cases, the virtues establish a climate in which rational deliberation can occur. The need for the virtues, but not the virtues themselves, is derivable from principles. Motivation is a very important contribution of virtues.

I am not asserting that virtues are a separate morality which can solve all problems in the moral life. Virtues have a complementary role to principles. But, to assert that virtues only have an instrumental role for principles, as Veatch does (Note 12), is to argue for too weak a position for virtues. An analysis would probably show that virtues are complementary to casuistry in ways similar to their relationship with principles. My discussion of Carse's essay, in the Appendix to the Introduction, suggested that analysis of the "care orientation" may also demonstrate essential roles
for virtues. Her essay is also a good argument for an essential place for the "care orientation" in morality.

My present concept, although very incompletely developed, is that the moral life probably requires interaction of principles, virtues, casuistry, rights, and the "care orientation." It remains to be seen if this view is correct, and if some overarching theory can tie these approaches together. A consideration of the relationship of these approaches is beyond the scope of this project.
NOTES


2. As I discuss in detail in Chapter Four, learning a virtue may be best achieved by an attempt at practice of the virtue, followed by reflection on practice in the light of the theoretical conception of the desired virtue.

3. See my discussions of the virtues of compassion and care in Chapters Five and Six.


5. Konner, 263.


8. See Chapter Six for a discussion of practical wisdom.

9. This claim is open to other interpretations. This is mine.

10. I am distinguishing power and control. Power is the potential to control. Control is the use of power to dominate the other person.

11. See my arguments about the nature and importance of humility in Chapter Six, in which I provide a detailed discussion of each of a tentative list of physicians' virtues.


13. See my extended discussion of the virtue of compassion in Chapter Six.

14. An example of an incentive is others' praise for one's efforts. Examples of disincentives are the possibilities of peer criticism, censure and litigation if one does not fulfill one's obligations as a physician.
CHAPTER FOUR

The Nature of a Virtue

The virtues may be essential for physicians, but it remains to be shown that a systematic, appropriate set of virtues can be developed for medicine. Chapters four through seven are an initial effort to develop the theoretical basis and the practical ground for virtues, and a tentative set of physicians' virtues. In other words, this is a first attempt to sketch the features of a virtue theory for medicine. A complete virtue theory for medicine would require at least the following. (1) A definition of the general nature of virtues. This objective would require a substantial review of contemporary scholarship on virtues. (2) Identification of the goals or ends of the virtues of physicians. As I discuss in the next chapter, this objective will require determination of the purposes of medicine, the nature of medical practice, and the character of modern patients' experiences in the health care environment. (3) Derivation of the set of physicians' virtues from (1) and (2). (4) An explanation of how virtues relate to principles, rights, etc. That is, the position of virtues of physicians in relation to other approaches of physicians to moral issues in medical practice. My preliminary thoughts about this concern were noted at the end of the last chapter. (5) Adequate rebuttal of criticisms of the
virtue approach. (6) Consideration of the best means of teaching virtues.

It would take several volumes to set out these elements of a virtue theory for medicine. But at least two other steps would also be required for significant progress in the teaching of virtues to physicians. First, the form and content of a program for teaching virtues in medical education institutions would have to be developed and instituted. Second, the outcomes of those teaching efforts would have to be evaluated. From that evaluation, the form and content of the program would probably need to be revised. Although I cannot do most of the above work here, I have begun it by sketching some pertinent features of steps (1), (2), (3), and (5) in what follows. I have grounded these initial proposals in Aristotle's seminal work on virtues, the Nicomachean Ethics.

A virtue theory is developed from two bases—a moral psychology and a concept of the good. By a moral psychology, I mean a conception of human psychology that explains the mental, emotional or spiritual aspects of moral life. Important issues in moral psychology might include the nature of moral deliberation and decisions, the role of the will, the nature of moral character, the relationship of moral character to moral actions and so forth. The moral psychology of a virtue theory explains the nature of a virtue—what it is, how it develops, and how it works. The core concept of the moral
psychology of virtues is that they are certain sorts of habits, character traits or dispositions to feel or to act.\textsuperscript{1} Virtues develop from repeated actions or feelings which are at first rudimentary, incomplete and off the mark. As a person keeps practicing "at" the virtue, the proper disposition becomes identified, understood and incorporated into the person. An example is fidelity or promise-keeping. As a child, I might keep or break promises, depending on whatever is most useful. My parents and older siblings advise me not to break promises, may punish me for breaking them, tell me to why I should keep promises, and demonstrate fidelity. I learn that I should keep promises and, as I more often keep them, I get the habit of fidelity. Eventually fidelity is a part of myself. Keeping promises is what I do. Repeated activity of a certain kind, i.e., keeping promises ultimately determines my disposition. I can only develop fidelity by keeping promises.\textsuperscript{1}

Keeping promises also involves skill and judgment. Physicians, for example, are bound not to reveal confidences from patients to third parties except when permitted by patients or if there are reasons that have priority over this covenant, such as danger to other individuals. Examples would be needs to inform partners about some infectious diseases and the need to warn others against potential violence by the patient.\textsuperscript{1} Physicians must sometimes, therefore, override their disposition of fidelity because of the greater needs of
other patients. The action that would be the outcome of a virtue does not always occur because practical wisdom intervenes. There is also a relationship among skills, virtues, and practical wisdom. The virtue of honesty, for example, may require considerable skill in application. Suppose honesty requires that I must give a patient bad news. Do I give the news crudely or diplomatically, quickly or slowly? What words do I use? These applications require skills which I use to be honest in the appropriate fashion, guided by practical wisdom. An example from sports will further illustrate the nature and relationship of virtues, skills and practical wisdom.

Excellence in sports is limited by an athlete's innate capacities, but capacities are only the ground for athletic excellence. Capacities are the bases for development of skills, and the application of skills is guided by an analogue of practical wisdom--call it "athletic savvy." Athletic savvy is a gradually learned attribute that integrates instant sensory information with other knowledge to determine what action the player should execute at any moment. Athletic excellence comes from highly developed skills applied with guidance from athletic savvy, and savvy is informed by the purposes of the sport and strategies for winning. Skills are built from layer upon layer of more and more complex movements, starting with the most rudimentary movements and
relatively undeveloped capacities. Here is a fuller example from soccer.

Some capacities required for excellence in soccer are speed, strength, coordination, quickness, stamina, and intelligence. These native endowments set the upper limits of each skill, but they are only the ground for soccer skills. Players must learn how to kick the ball with either foot, dribble it, head it, coordinate their actions with those of other players, sprint at the right time, fake at the right time, know how and when to slide, and so forth. Players learn to kick a soccer ball by kicking it, but it must be kicked in the right way and there are many different ways to kick it, depending on the circumstances and inclinations of the player. Each way of kicking the ball requires a related, but different set of psychomotor skills. When first learning to kick a soccer ball, the right kind of kick is demonstrated. The player then repeatedly kicks the ball. Efforts are first clumsy, then gradually more effective, the level of skill achieved depending on the player's diligence, instruction, and innate capacity. At first each movement requires concentration on what the foot is doing in relationship to the position of the ball. Since the movement of the beginner's foot and leg will be poorly coordinated with the movement of the ball, strength is often misdirected. With coaching and practice, errors in kicking are gradually corrected and execution is closer to ideal. Numerous subtleties of
execution are added with years of practice. After these skills are learned, their execution becomes automatic, not requiring conscious thought. Players retain their skills as long as the sport is practiced and their capacities are not impaired.

Good players move the soccer ball while being aware of what nearby and distant players are doing, while fending off opponents' attacks and while sprinting. Athletes speak of the rewards of a well executed maneuver and the thrill of carrying through with a plan that leads to winning the game.

Virtues are habits which have some similarities to the skills of good soccer players. Repeated attempts to be virtuous instill the virtues into a person's character, just as soccer skills ultimately become automatic and integrated into a player's behavior. As Aristotle puts it, one becomes just by acting justly and self-controlled by acting with self-control. The way of acting or feeling becomes incorporated into one's character by repeatedly performing the action or feeling the emotion. Just as a soccer player becomes more and more skillful, with greater and greater degrees of sophistication, a virtuous disposition becomes more and more strongly ingrained into a person's character and its applications are understood in greater depth.

There may be a difference between a virtue and an athletic skill in what is required for maintenance. Once a person has acquired a particular virtue, that individual will
always have that disposition and will not behave otherwise unless a conscious effort is made to do so. For example, if I am honest, I am always honest. If I am a soccer player and do not play for six months, however, my skill declines. But there is still some similarity between virtues and athletic skills, even when qualified in this way. For example, consider the virtue of courteousness. Courteousness is applied in multiple ways, triggered by sensitivity to people's needs and years of practice in determining how courtesy is best applied. Courteousness therefore includes a complex group of skills and may require sophisticated judgment. When one is regularly in circumstances that bring out a virtue like courteousness, sophisticated applications take little deliberation, they are relatively habitual. But when one is long in situations where courtesy is not needed or suppressed, such as living alone for months or when a prisoner of war, courteousness may be quite crudely applied when the person is back in ordinary circumstances. Thus, virtues are habits which are permanent dispositions, but skills in applying those dispositions are important and can decline. Habits or dispositions can also be impaired by mental illness or intellectual impairment. Just as an athletic skill is automatic or part of the person, but yet is guided by the player's athletic savvy, a virtue is ingrained in a person, but guided by practical wisdom.
Aristotle divided virtues into the intellectual and the moral. The intellectual virtues are acquired through teaching, but the moral virtues are developed through practice and are habits. As in soccer, repeated applications make patterns of feeling and acting relatively automatic, so that deliberation and acts of will are not required for most executions. The first attempts at virtuous actions are likely to be crude and uncoordinated, hitting wide of the mark and applied without finesse. Repeated applications lead to fine tuning of the disposition, with gradual development of numerous subtleties and greater skills, just as we become a good harpist by playing the harp.

Aristotle proposed that a virtue is learned through practice at finding the mean in feelings or actions. Too much or too little of the feeling or actions are vices.

... it is a mean in the sense that it aims at the median in the emotions and in actions. That is why it is a hard task to be good; in every case it is a task to find the median: for instance, not everyone can find the middle of a circle, but only a man who has the proper knowledge. Similarly, anyone can get angry—that is easy—or can give away money or spend it; but to do all this to the right person, to the right extent, at the right time, for the right reason, and in the right way is no longer something easy that anyone can do. It is for this reason that good conduct is rare, praiseworthy, and noble.

Virtues are ingrained character traits developed through practice. Each virtue functions in a substrate of feeling or action. A substrate is a certain occasion, or type of human activity that has attendant feelings or actions. A substrate
is a important "sphere of human experience." As Nussbaum characterizes them, examples of Aristotle's spheres of experience include "fear of important damages," "distribution of limited resources," "giving of material goods," "attitude to slights and damages," etc. Each virtue is the disposition to just the right attitude (feeling) or action within the substrate or sphere of experience. Each sphere is an area in which some choices or some actions are more appropriate than others.

Most substrates not only have associated virtues, but also vices which are excesses or deficiencies of the disposition to the feeling or the action. When there are vices of excess and deficiency, there is a range in between them which marks the boundaries for the virtue. Thus, the vices may help locate the virtue. As Aristotle put it, a virtue

"is the mean by reference to two vices: the one of excess and the other of deficiency. It is, moreover, a mean because some vices exceed and others fall short of what is required in emotion and in action, whereas virtue finds and chooses the median."

Aristotle implies that a virtue occupies a certain range between the two vices. For a given individual, however, there is only one point, a specific action or feeling, which represents the virtue for that person in a particular circumstance. Aristotle is allowing for variable human capabilities which somewhat alter what is the virtue in a particular circumstance for each person."
Some modern debate has centered about the problems of how to judge if a person is virtuous, since knowledge of the agent's inner orientation seems critical for that judgment. Aristotle held that persons' actions had to be for the right reasons if the actions were virtuous, but how can persons' reasons be assessed? How can we determine what sort of person someone really is? The emphasis in virtue theory is on agents, but if we only observe their acts, how then can we judge the agents? Consider the question of whether someone's virtuous act is done for its own sake, or for some external reward such as money or glory. How confident can we be that the person's rewards are internal, e.g., that somehow the motivation associated with the virtue and reward of having the virtue are present, and that they are sufficient bases for the person's acts?!

If persons are taught and practice the virtues, then many of them will become virtuous and can be observed to act as virtuous persons would. The critics are correct that we can never judge if a particular act shows that someone has a virtue. But, if we observe that such a person's acts and sentiments are consistently in accord with what a virtuous person would do, then we can judge that the person, at least, probably has the virtues. I agree with these critics that we can never determine if moral agents who act virtuously are also virtuous in their hearts. This critique has important implications for the teaching of virtues to which I can only
allude here, but which should be addressed in a more complete work.

Although virtues are ingrained dispositions, they sometimes need guidance by practical wisdom. A moral agent cannot be virtuous without practical wisdom and practical wisdom exists for the sake of being virtuous. As Aristotle put it, "... it is impossible to be good in the full sense of the word without practical wisdom or to be a man of practical wisdom without moral excellence or virtue." For Aristotle, practical wisdom is a deliberative faculty which is exercised as needed by the circumstances. Moral agents use their intelligence to monitor their life experiences. They have virtues that are dispositions to respond in the right way for the particular situation. Often the agent's practical wisdom only observes (monitors) the habitual response. For example, suppose an elderly, disabled woman is crossing the street. The courteous agent helps her across the street without any struggle of will about doing it. The agent's practical wisdom assesses the situation and determines that the virtuous response should not be modified. But now suppose that there is a car careening down the street. The best judgment then would be to remove the woman rapidly from the street, perhaps requiring another virtue, such as courage. Suppose a situation calls for kindness, but the act of kindness would keep one from something pleasurable. The temptation instead to do the pleasurable thing would have to
be ignored. This is why Aristotle said that virtue, practical wisdom and moral strength are inseparable. Practical wisdom includes knowledge of what should be done and the moral strength that insures the action by keeping the moral agent from yielding to temptations."

Moral virtues are habits. Practical wisdom is an intellectual virtue needed for monitoring and guidance of the moral virtues. How are virtues learned? Virtues are learned by practice. The idea of what a virtue is like can be learned from paradigmatic persons by observation or through stories about them, and by studying descriptions and features of virtues. The earliest examples of virtues are often observed in one's parents. Character traits begin forming in childhood, but molding of character can continue in later life, perhaps throughout life. Intense training and learning circumstances, like medical school and residency, are particularly strong influences on persons' character traits. There is a substantial literature that documents the modifications of values and attitudes of medical students as they obtain their medical education and training. I have already described some of the virtues that were instilled in us when we were house officers at Johns Hopkins. Similarly, I believe medical students and many physicians, provided they have some disposition to be virtuous, can be taught the virtues and learn to be more virtuous. My experience with the life and writings of William Osler is a good example. I know
a lot about the kind of person he was and have tried to emulate him. Over the past twenty-five years, since I first heard about him from my college friend, I have repeatedly visited Osler through his essays or some article about him. I have reflected on my traits and have tried to use his example to hit closer to the mark that represents the virtue that Osler displayed.

The most rudimentary form of learning virtues from role models is simple emulation. A role model does such and such in a particular circumstance. The trainee acts similarly in like situations and gradually the trait becomes incorporated into the trainee's character. It is most helpful if trainees can describe their paradigms in various circumstances that demonstrate different virtues and the paradigm's practical wisdom. Students of virtues can also learn from paradigmatic persons through close study of good biographies. But simple emulation is insufficient, of course, as the moral life is too complex. Virtues require different responses in different cases. Through practice, trainees in virtue gradually incorporate the traits into their character. Traits or virtues become ingrained but are not immutable, as they are informed, refined, and modified by repeated practice and reflection on one's own and associates' encounters. Through experience, one develops rough, but better and better guidelines for practical wisdom. Rough guides are all that is possible since ethics is not an exact science. One
gradually develops virtues and in the process becomes a good person.

I have argued that there are two bases of a virtue theory. The first basis is a moral psychology which includes the core concept that virtues are certain sorts of habits which are dispositions to feel or to act. The second basis of a virtue theory—the good—is discussed in the next chapter.
NOTES


15. *Nicomachean Ethics*, II, 6, 1107a1-5.


17. My position is that motivation is intrinsic to virtues, a claim which is true by the definition of a virtue. This is a claim about the relationship of virtues and human psychology which needs substantial defense, a defense which I will not attempt in this essay.

19. **Nicomachean Ethics**, VI, 5, 1140a25-1144b36; VII, 10, 1152a7-10.


21. An excellent modern example of a helpful biography, in my opinion, is William Manchester's study of Winston Churchill. Manchester does a remarkable and exhaustive job of analyzing and demonstrating the qualities, motivations, and acts of the heroic, contradictory, resilient, energetic, productive, and brilliant man that Churchill was. See the first two volumes: *The Last Lion: Winston Spencer Churchill, Visions of Glory, 1874-1932* (New York: Dell, 1983) and *Winston Spencer Churchill - The Last Lion: Alone, 1932-1940* (New York: Dell, 1988).

CHAPTER FIVE

Derivation of the Virtues of Physicians

The fundamental question for a general virtue theory, as for any teleological theory, is "what is the good life for a human being?" That is, toward what end should the moral life be directed? This question is also expressed as "what is the good?" The virtues are the means to the good. Virtuous agents achieve the good by living the virtues. A virtue theory must therefore supply a definition of the good. A virtue theory not restricted to any particular sphere of human life must identify the good which holds true in general--for everyone at all times. For example, the good for Aristotle was eudaimonia (usually translated as "happiness" or "flourishing"). He argued that eudaimonia is the greatest good achievable by humans. In his view, since happiness is best achieved by fulfilling one's function as a human, and since virtues are traits which are means of fulfilling that function, virtues are the means to the good.

An adequate virtue theory for medicine, however, can be developed from an answer to the more restricted question of "what is (or are) the good (or goods) of medicine?" The question can be restricted because medicine's attention is confined to issues related to health and illness. The job of developing a virtue theory for medicine can therefore be

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confined to identifying the proper ends or goods of medicine and the virtues of physicians which will adequately serve those goods. The virtues of physicians might suffice to make physicians virtuous in general, and I suspect that they would, but that possibility need not be investigated here. All I need to show is that physicians' virtues will foster the goods of medicine. I acknowledge that physicians, or any other persons, must have the general disposition to be virtuous if they are to acquire virtues. If physicians understand the goods of medicine, and if they understand that they are seeking the goods of medicine as they try to learn the virtues, then they are motivated to continue learning the virtues.*

Examination of the goods of professions in general may reveal goods that are essential in medicine, but that might not be evident from within medicine. It cannot be assumed that the values and purposes of medicine have remained consistent with the general purposes of professions. It is quite possible that a particular discipline such as the profession of medicine may lose sight of some of its primary goals and values. A step back to the general goods of professions makes it less likely that essential goods of medicine will be missed or that something is erroneously judged to be a good of medicine. I will, therefore, start with the goods of professions in identifying the good(s) of medicine. Some of Edmund Pellegrino's work can provide one basis for this effort.

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Pellegrino recently argued for six characteristics of professional-client relationships which

"...generate a kind of 'internal morality'—a grounding for the ethics of the professions that is in some way impervious to vacillations in philosophical fashions, as well as social, economic or political change."

Since I believe that Pellegrino's six characteristics allow identification of the fundamental good of professions, as he implies, I have paraphrased his claims and arguments below. I add some commentary after each characteristic is summarized.

It is worth noting that Pellegrino does not provide significant evidence that these are the primary features of professional-client relationships. He presents these characteristics as if they are empirically observable, with no sociological or historical justifications. Since analysis of the characteristics demonstrates that there are irrevocable moral features of professional-client relationships, Pellegrino implies that there are normative implications for professions. Some features of his conclusions are noted after the discussion of the six characteristics.

(1) Clients are easily exploited because they are dependent, vulnerable and exploitable. Patients, for example, are fearful and distressed.

Patients are very vulnerable to exploitation since they are often frightened by the presence or possibility of disease, bewildered by the strangeness of the health care environment, overpowered by institutional bureaucracies, and
dependent on doctors' knowledge. Although self-help groups and lay publications have reduced patients' ignorance and fostered involvement in their own health care, reducing their exploitability, patients' vulnerability and dependency largely remain.\(^1\) Physicians' superior knowledge and technical competence are not achievable by most patients in most circumstances.\(^4\)

(2) Professionals' superior knowledge gives them power over their clients. Since professionals control use of professional knowledge, it is not a relationship between equals, invalidating the notion that professional-client relationships are analogous to contracts.\(^5\)

Most patients do not have enough understanding to assess physicians' advice. Some parity of knowledge can be obtained through second opinions and study of medical literature, but most patients cannot take these options. In life-threatening emergencies, patients often must unquestioningly accept their physicians' advice. In some instances, physicians can give their patients more control by providing education and encouraging second opinions, but Pellegrino's point is that the physician has the power in the relationship, and largely controls how it is used. A contractual model will not work for the relationship because a valid contract assumes equality of the contractors.

(3) Characteristics (1) and (2) require that clients trust their professionals to use their knowledge well and for
clients' benefit. Clients usually cannot assess professionals' competence and the appropriateness of professional advice. Clients must give confidential information to professionals in order to be helped. Since professionals publicly proclaim that their purpose is to help their clients, professionals imply that they can be trusted to act for the interests of their clients."

Although patients have some remedies if physicians are negligent or do not use their knowledge for patients' best interests, patients' ignorance forces them to trust their physicians. Over a long relationship with one doctor, a patient can often determine whether a physician can be trusted to be altruistic, but patients are less able to assess competence. Many medical encounters, such as consultations with specialists or visits to emergency department physicians, occur between patients and physicians who do not know each other. In such cases patients often have little choice but to trust that these physicians are competent and altruistic.

(4) Professionals' knowledge must, at least in part, be for clients' benefit. Professionals' knowledge cannot be solely used for their own gain. Society fosters the education of physicians, literally allows students and trainees to practice on patients, in order that physicians will gain knowledge that is to be used for patients' benefit."
professions the privilege of regulating themselves. The expectation is that professions will act for clients' interests. These gifts and privileges establish a clear obligation of physicians to use their knowledge primarily for patients' welfare. Physicians are not free to use their expertise for their own benefit in any way they might choose.

(5) Professionals are the avenues for, and governors of, the transmission of the profession's expertise to the client and they have promised to act for their clients' welfare. Policies, laws and regulations are effective only in so far as the professional follows them in relationships with clients. Professionals, therefore, are accountable for their actions and are protectors of their clients' interests."

The knowledge of professions flows through professionals, who also control that flow. The earlier arguments establish that professionals have promised that they can be trusted to act for their clients' interests. Since physicians have control of what they advise and do for their patients, physicians can be held responsible for their acts.

(6) All professionals are members of a group which has pledged to use its special knowledge for the welfare of its clients. Each professional is responsible to the group and the group is responsible for the professional actions of each member. Professionals are not free to make independent judgments about their responsibilities and privileges. Each
professional group has made certain promises to society and individuals are not free to abrogate those promises."

Professions are obligated to act for their clients’ benefit. This obligation holds for the collective and individual acts of a professional group. The profession of medicine must therefore always act for patients’ benefit and individual physicians must do likewise.

These six characteristics establish that professions have irrevocable moral features based in their relationships with, and promises to, clients. The chief or final good underlying these characteristics is the benefit of clients. Professions claim to have special knowledge that will benefit clients. Professions promise to help their clients with that knowledge and to use their knowledge primarily for clients’ benefit."

Patients, then, must primarily be ends and not means. Since the good of professions is, therefore, the benefit of clients, the chief good of medicine is the benefit of those clients (patients) whose problems fall within the purview of medicine. Physicians cannot appropriately put themselves in situations where conflicts of interest make it likely that patients’ interests are not primary."
The virtues of physicians will therefore be those character traits which foster the benefit of patients, including those virtues necessary to prepare for, and to maintain competency in, the expertise of the profession.
Patients benefit from assistance with the problems that fall within the domain of medicine. The domain of medicine can be identified by the purposes of medicine. I propose that the primary purposes of medicine are to prevent, heal or palliate illness. I define illness as an affliction of persons which causes, or may cause, death, disability, pain or suffering. Afflictions include injuries. The afflictions of an illness, working from George Engel's "biopsychosocial" model, often include the interactive, or interrelating, spheres of mind, body, psyche, emotions, spirit, families, friends, job and community. Medicine generally considers illnesses to be only those afflictions which are potentially understandable or treatable by methods, techniques and substances which medicine has developed in the modern era and attempts to validate scientifically. This definition of illness will include cases in which there is no clear boundary between appropriate and inappropriate objects of medicine. For example, where do the responsibilities of medicine and individual physicians stop, and the responsibilities of the community or the state start, when the root cause of an illness is poverty? Physicians may disagree about the boundaries of medicine in such cases, and some physicians may have a more constricted or broader definition of illness than mine, but these disagreements do not occur in most cases in medical practice. I suggest that these disagreements also do not significantly change the list or meaning of physicians'
virtues. Narrower or broader concepts of the scope of illness will change what a particular physician believes is the proper object of virtues, but not what are appropriate virtues for physicians. I acknowledge that this is a key claim which would require a significant exposition to defend adequately.

Two other bases of physicians’ virtues remain to be clarified—the nature of medical practice and patients’ experience of illness. The following features of contemporary medical practice have significant implications for physicians’ virtues. (1) Illnesses vary in complexity, outcome, predictability of course and outcome, response to treatment, duration, urgency of need for care, and likelihood of morbidity and mortality. Physicians, therefore, must routinely cope with uncertainty, death, or bad outcomes, emergencies, and chronic illnesses. Physicians have to deal with patients’ and families’ anger, hostility, despair, suffering, and grief. Physicians may have to undergo considerable personal inconvenience and physical discomfort. (2) Some diseases, such as the acquired immunodeficiency syndrome (AIDS), pose risks for physicians. Physicians, therefore, may have to accept personal danger in their work. (3) Many tests and treatments are available to modern physicians. They may, therefore, often have many details to consider and to act upon for each patient. (4) Physicians practice medicine in a social structure that increasingly requires collaboration and cooperation. Physicians must, therefore, share power and control with their
health-care colleagues. (5) Physicians are exposed to many temptations, including financial gain, power, fame, and adulation. Physicians must, therefore, have personal qualities which counter these temptations.

Patients' experiences of illness, some of which are peculiar to the modern era, often include the following that are pertinent to physicians' virtues. (1) Patients commonly experience suffering, which may include pain, life disruption, and various losses. (2) Patients usually fear suffering, death, or bad outcomes. (3) Patients frequently have loss of personal control, strength, stamina, assertiveness, other social skills, and personal dignity. These losses increase patients' vulnerability to adverse influences." All of the factors in (2) and (3) worsen suffering. Physicians, therefore, must have means of preventing, sensing, and palliating, reducing, or eliminating these sources of patients' distress.

The components of the ground for physicians' virtues have now been established. The chief good of medicine has been established as the benefit of patients. It has been clarified by examination of the purposes of medicine, pertinent features of medical practice, and patients' experiences of illness. This ground is the basis for deriving the virtues of physicians.

Since the chief good of medicine is the benefit of patients, benevolence is the primary virtue of physicians. Since doctors promise to act for their patients' benefit,
trustworthiness is the second primary virtue of physicians.° Pellegrino argues that these are the two primary virtues of professionals. I propose that Pellegrino's six characteristics of professional-client relations yield another primary virtue of physicians—respectfulness. The promise to act primarily for patients' interests and not to take advantage of their reduced power and control is a promise to treat clients primarily as ends and not as means.° This promise, in other words, assumes that people have inviolable worth or dignity. Respectfulness, then, is the virtue of maintaining respect for persons' inviolable worth, which they have simply by being persons.

Since medical knowledge and skills require years of study, training, and practice to acquire, all professionals need virtues such as perseverance and diligence. Alasdair MacIntyre argues that the virtues of justice, courage, and honesty are also necessary for achieving competence in a practice.° Courage allows students to take the risks needed along the way to acquire the knowledge. For example, students may have to make considerable financial or physical sacrifices for the years of study necessary to learn their profession. Honesty fosters admission of one's ignorance, a necessary prelude to learning. My view is that humility is also essential for professional competence, because humility prevents arrogance. Arrogance is important to prevent because it may block students' perception of their ignorance.
MacIntyre states that justice fosters giving credit to those practitioners to whom it is due. He does not make it clear why he thinks justice is important. What he seems to mean is that if a student inappropriately accepts credit for what the student has not done, this injustice is another intellectual obstacle to understanding what else the aspirant must learn to be competent. In this conception, honesty, humility and justice establish the "intellectual honesty" that is the best possible ground for learning. Courage, honesty, humility and justice also have particular importance in medicine. The virtues necessary for preparation for medicine are important for medical practice as well. Many illnesses require that physicians persist and work hard. That is, medical practice requires perseverance and diligence. As illustrated earlier, patience and equanimity are commonly required too. As patients must be treated fairly, and since care may present risks to the physician, justice and courage are essential virtues for physicians in practice. Since truth-telling is a cornerstone of trust in doctor-patient relations, honesty is essential for practicing physicians. Physicians must resist temptations to overpower patients and must collaborate with colleagues. Humility is therefore a crucial virtue for physicians in practice as well.

Since illness usually includes suffering, compassion is a crucial and central virtue for physicians. Physicians need to respond to patients' during illness and to preserve
their personal dignity. **Care** is a virtue essential for meeting those needs. **Conscientiousness** is a virtue required for effective attention to the myriad of details of medical practice. These moral virtues of medicine are supplemented by the intellectual virtue of **practical wisdom**, which is needed to monitor the moral virtues and sometimes to set priorities among them.

This analysis has suggested a tentative list of virtues for physicians. The final phase in determining if a list of virtues for a profession is comprehensive and appropriate ought to include analysis from a perspective outside of the professions. As they mature, professions have a tendency to forget some of their fundamental obligations to clients. The investigation ought to determine if the interests and values of their clients (including all those who have a right to be clients) have been violated by the set of virtues or if other virtues are needed. Possible ways to obtain perspectives outside medicine would include reviews of litigation, polemical works about medicine and studies of physicians' and professions' misadventures. Throughout this consideration I have tried to give such works fair consideration.
NOTES

1. By "general virtue theory," I mean a virtue theory intended for life as a whole, rather than a part of life, such as the practice of medicine.


4. There are a number of interesting issues to consider in determining a good for a virtue theory. Some are noted below.

(1) It is possible that a universal good exists for humans. An example is Aristotle's eudaimonia (happiness), as discussed and cited in the text.

(2) Even if there were a universal good, it might not be discovered. It also might not be discoverable. One can postulate that humans are capable of understanding everything about themselves, but this is only a hypothesis and is not demonstrable.

(3) There may be no universal good.

(4) Even if a universal good is not discovered, philosophers could agree on a good ("acceptable good") that would constitute the practical ground of a virtue theory. Philosophers could decide that their scholarship revealed a concept of the good which was not necessarily a universal good, but that it was defensible as an adequate ground for a virtue theory. They might believe that much more scholarship would be required before they could be sure that "the good" had been discovered. By "practical ground," I mean that their scholarship would suggest that this good would inform the virtues for most circumstances in practice.

(5) Philosophers might discover a universal good or establish an "acceptable good," but they might have problems determining what virtues should be derived from that good.

They might, for example, not have enough understanding of human psychology to develop an adequate list and definition of the virtues. Philosophers also might have insufficient knowledge of the practical ground of the moral life—the kinds of problems that ordinary people encounter.

(6) Even if philosophers could discover a universal good or establish an "acceptable good" on which to ground a virtue theory, this would not assure that this good would be widely accepted by moral agents.
Philosophers might not be able to convince moral agents that the "acceptable good" is adequate for a virtue theory. Alternatively, practitioners might ignore the concept of the good and assess the practical value of the virtues derived from that good.

(7) Even if there were a universal good or an accepted good, and practitioners accepted this good, and even if a coherent and comprehensive set of virtues could be worked out, people might not accept those virtues.

It is insufficient for a virtue theory to be theoretically valid. If a virtue theory is going to work for the moral life, moral agents (or their teachers) must accept the validity of a set of virtues and the virtues must be validated in practice. (Assessing the practical effectiveness of a moral theory requires at least a determination of the meaning of effectiveness and then an adequate measure of that effectiveness. Both objectives would be difficult.)

5. Personal communication from Professor Richard Walton.


8. I distinguish medicine from health care. Medicine is practiced by physicians, nursing by nurses, etc. Physicians, nurses, respiratory technicians, pharmacists, etc., are all health care professionals.

9. Alasdair MacIntyre refers to the goods internal to practices which are achieved by the virtues. He argues that practices are circumscribed activities in which there is little disagreement about the nature of the good. MacIntyre's concepts about practices underlie much of the work in this chapter. (Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, 2d ed. (Notre Dame: Notre Dame Press, 1984), 191.

10. Edmund D. Pellegrino, "Character, Virtue and Self-interest in the Ethics of the Professions," *Journal of Contemporary Health Law and Policy*, 5 (1989), 67. Pellegrino was particularly looking for a philosophical foundation for virtues that would reduce current tendencies of professionals toward fostering their own interests over those of patients, but these characteristics are generally useful for a virtue theory for medicine.


14. Some patients, such as those with rare chronic diseases, understand more about their condition than many of their physicians. Even these patients, however, are dependent upon physicians to write prescriptions, order and interpret tests, and perform procedures or surgery.
21. This is much easier said than done. Much of contemporary fee-for-service medicine puts physicians in continual conflicts of interest. It has been proposed that health maintenance organizations (HMO's) improve patient care by eliminating such conflicts, but HMO's sometimes bias physicians against offering patients necessary goods and services. These outcomes support arguments for salaried physicians whose rewards depend primarily on the quality of their patient care.

22. Medicine can also be characterized as the maintenance and restoration of health, but the focus on illness, as discussed below, allows inclusion of palliation, a very important part of medicine.

23. Pain and suffering may not be the same. See the discussion of compassion in Chapter Four.

24. George L. Engel, "Clinical Application of the Biopsychosocial Model," in Medicine as a Human Experience, David E. Reiser and David H. Rosen (Rockville, Maryland: Aspen Systems, 1985), 47. I include families, friends, etc., following George Engel's lead, because I am convinced that the meaning of illness is partially dependent on persons' relations to, and interactions with, these larger life spheres. Medicine's language, and physicians usual repertoire of skills, however, are poorly equipped to deal with this conception of illness. Our dualistic concepts of mind and body are associated with the absence of any single term that captures mind and body in a unit. I have added the terms "psyche, emotions and spirit" because none of our terms capture all that we think of as functions of the mind.

25. In short, medicine generally includes in its scope those entities which fit in the disease category, which is reductionistic, and whose cause is potentially explainable by the scientific model. See Medical Thinking: A Historical Preface, by Lester S. King (Princeton: Princeton University Press, 1982) for an excellent historical overview and analysis of concepts of disease and causality in medicine.

So that the reader does not think that I have some naive idea that medicine is purely a science, I add that practitioners' approaches to illnesses include many modalities which are important and not generally understood to be science—often called the "art" of medicine.

26. A claim based on my own experience.


29. I say "primarily" as ends because no conception of physician–patient relations would deny that patients are the means to some ends for physicians, such as livelihood, intellectual stimulation, rewards of giving service, etc..


31. MacIntyre's justifications on this topic are not significantly elucidated. He was considering not just professional competence, but what was necessary to achieve what he called the goods internal to a practice. The latter, in his conception, are achieved through excellence in the practice. But, these virtues are necessary for obtaining professional competence as well.

32. See the next chapter.

33. See case IV, Chapter Two.

34. Not all illness includes suffering, if suffering is defined as pain which causes mental agony, including some type of existential crises, as discussed in chapter six in regard to compassion. For example, a person in a chronic vegetative state has no higher brain function and cannot suffer as far as we understand. Another, more common example, is when a person incurs minor pain, but usually no suffering for a procedure, such as the periodic freezing of premalignant skin lesions.

35. The word, "mature," is used advisedly. Paul Starr notes the medical profession's efforts to improve and maintain its authority, status and income. These moves have had no relation to the needs of patients. (Paul Starr, The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry (New York: Basic Books, 1982), 27, 78-79). Bledstein states that a major tendency of professionals is to protect their autonomy against all assaults. (Burton J. Bledstein, The Culture of Professionalism: The Middle Class and the Development of Higher Education in America (New York: Norton, 1976), 92.).

   Professions, and individuals, however, are not bound to respect what society values in all circumstances. An example of inexcusable acts by physicians, even though they followed the dominant value of that society, would be the participation of the Nazi doctors in the holocaust. See Robert Jay Lifton's The Nazi Doctors: Medical Killing and the Psychology of Genocide (New York: Basic Books, 1986).

36. For example, see Paul Starr's, Burton Bledstein's, and Robert Lifton's works cited immediately above. Another sort of example is Katz's study of doctor–patient interaction. This polemic argues for a radically different and fuller conception of what happens between doctor and patient, including many unconscious factors motivating physicians. (Jay Katz, The Silent World of Doctor and Patient (New York: The Free Press, 1984).)

37. Another interesting way to consider classifying virtues might be to distinguish between virtues and "moral strengths." The possible need for this distinction is shown by how we use terms in conversation. We speak of a good person as having courage, but we would not speak of an evil person as having courage, although we speak of the latter as doing something courageous. Aristotle also wrote of people who
act like they have courage, but do not have the virtue of courage. Instead, circumstances may coerce them to act as if like they have courage. (Nicomachean Ethics, III,8,1116a18). On the other hand, there seem to be some character traits or virtues, like perseverance, that we might be comfortable applying to either good or evil persons. For example, we would probably agree that Hitler had perseverance, although with disastrous consequences. Perhaps perseverance is then not a virtue, but some other type of quality which might be called a "moral strength."

I believe this difficulty suggested by our use of language is resolved if we consider the two bases of a virtue theory previously considered—moral psychology and the good. The moral psychology explains what sort of characteristic a virtue is and the good is the end which is the ultimate purpose of the virtue. Thus, Hitler had the habit of perseverance, but he did not have the virtue of perseverance because it was directed toward the wrong ends.
CHAPTER SIX
The Virtues: Definitions and Explanations

This chapter first defines, then justifies and explains the virtues of physicians. I follow the Aristotelian approach, outlined in the previous chapter, of defining each virtue by identifying (1) the substrate or sphere of human experience for each virtue's disposition to feel or to act, (2) the vices of excess and deficiency, and (3) the nature of the virtue which falls in the range between the vices. It is beyond the scope of this essay to give a full discussion of any virtue of physicians.

BENEVOLENCE

Management of medicine's resources in regard to patients' illnesses is the substrate of benevolence. Those resources include the skills, knowledge and time of physicians. Benevolence is the disposition to use medicine's resources to help patients by acts that prevent, heal, or palliate their illnesses. The vice of deficiency is selfishness, the use of medicine's resources primarily to benefit the physician. The vice of excess is selflessness in regard to the use of those same resources. Benevolent physicians benefit their patients by using their knowledge and skills, for example, to make diagnoses, prescribe treatments, and perform operations. Since the fundamental objective of medicine is the good of
patients, benevolence is a primary virtue of medicine. All other virtues of physicians must, therefore, foster the good of patients by preventing, healing, or palliating illness, except as noted below. Benevolence is not the primary virtue of physicians because such a status would lead to unmitigated paternalism by physicians. Since we recognize that competent adults usually should determine the extent to which they will use medicine's resources, the virtue of benevolence must be balanced by a disposition to respect patients' autonomy. The virtue of respectfulness can probably fill this role, as I outline in the next section.

Selfish physicians, in contrast to physicians with the virtue of benevolence, advance their own interests at the expense of patients' benefit. For example, selfish physicians may order unnecessary tests that give them higher profits or cultivate relationships with certain patients to gain power or status.

Physicians should not be selfish, but the benefit of patients is not the only purpose of a physicians' life. Physicians must attend to their own health, personal interests, obligations to family, community, etc. Physicians with the virtue of benevolence achieve a reasonable balance between their commitments to patients and these other areas. Physicians with the vice of excess, however, are disposed to use the resources of medicine for their patients' benefit without adequate regard for their own needs and obligations.
Such selfless physicians are especially disposed to harm themselves and their families by giving patients too much of their time, which is physicians' primary personal resource. Physicians with the virtue of benevolence, in contrast, arrange time to meet these other needs and obligations, while insuring that their patients receive adequate care in their absence. This is a general description of how physicians act who have the virtue of benevolence. If a patient unexpectedly needs the attention of such a physician, however, as in an emergency, the physician will attend the patient and postpone meeting other commitments.

RESPECTFULNESS

Attitudes and actions with regard to the worth or dignity of patients as persons are the substrate of respectfulness. Respectfulness is the disposition of having respect for persons. The vice of deficiency is disrespectfulness. I have no sufficient term for the vice of excess. Terms that come closest include 'fawning,' 'sycophancy' and 'obsequiousness.' Physicians with the virtue of respectfulness maintain their respect for each patient's inviolable dignity or worth, for patients status as persons, regardless of his or her circumstances. Physicians with the virtue of respectfulness, therefore, work to eliminate situations that degrade patients, and strive to enhance patients' dignity and autonomy. Such physicians, for example, keep patients adequately covered during examinations and treat them with courtesy. This virtue
is crucial, since the modern experience of illness may be very demeaning to patients and lead to great loss of autonomy, as previously discussed."

In the previous chapter, I argued that Pellegrino's six characteristics of professional-client relations yield respectfulness as an additional primary virtue of physicians. Respectfulness disposes physicians to treat patients primarily as ends. Respectfulness is a primary virtue of physicians because it is necessary to balance paternalistic implications of the virtue of benevolence. Without the virtue of respectfulness, physicians with the virtue of benevolence would be solely determining the good of patients. Consider a case in which it is certain that a woman will die unless her gangrenous leg is amputated, but she refuses the amputation on the grounds that her quality of life would be intolerable. The virtue of benevolence disposes the physician to amputate the woman's leg to save her life, as amputation is a quick, relatively painless, low-risk procedure. The virtue of respectfulness is critical because it disposes physicians to maintain respect for what patients value, even if what patients' value prevents their physicians' abilities to heal, prevent, or palliate patients' illness. Physicians with the virtue of respectfulness will generally work within the constraints of the patient's wishes. In the example cited, the physician would work to reduce the patient's suffering, while withholding life-saving amputation.
TRUSTWORTHINESS

Actions in regard to promises are the substrate of trustworthiness. Trustworthiness is the disposition to keep promises, to be faithful to commitments. The vice of defect is "untrustworthiness." There is no name for the vice of excess. It might be called "blind adherence to the letter of a promise." Trustworthiness is the third and last primary virtue of physicians. Physicians with the virtue of trustworthiness can be trusted by patients to keep promises, unless there are overriding reasons not to keep them. Untrustworthy physicians often do not keep their promises. Physicians with the vice of excess keep their promises despite appropriate reasons not to keep them. In the range between untrustworthiness and blind adherence to the letter of a promise, trustworthiness, is closer to the vice of excess. It is uncommon that promises should be broken, but common that they should not be broken.

The virtue of trustworthiness is most commonly essential when patients and physicians agree on a certain course of treatment. An example would be a decision between patient and surgeon about what will be done during an operation. The surgeon must be trustworthy to do the operation agreed upon unless important and unexpected findings indicate that the plan should be changed.

COMPASSION
Compassion functions in the sphere of feelings and actions in response to the suffering of others. Compassion is the disposition both to feel others' suffering as one's own and to respond to reduce their suffering. Compassion lies between the vices of total immersion in (excess), and indifference to (deficit), someone's suffering. A person with pity, in contrast, recognizes someone's suffering, but neither feels the other's suffering, nor responds to relieve the suffering.

Since suffering is a common concomitant of illness, compassion is a core virtue in medical practice. Compassion has long been thought to be an essential virtue for physicians, but the teaching of compassion needs resurrection in medicine and the meaning of compassion needs clarification. There has been important recent work on compassion.

Lawrence Blum defines compassion as a sustained and strong emotional reaction to suffering which engenders beneficent responses. He proposes that compassion is a response to someone whose significant suffering is evident and whose suffering can be imagined as happening to the observer. His concept is that compassionate persons put themselves in the sufferer's place through an act of imagination. Coupled with interest in the other's welfare, this identification motivates compassionate people to reduce the sufferer's pain—the compassionate response. Blum
claims that feeling the other's suffering requires imaginative transposition into the other.\textsuperscript{13} Blum notes that some compassionate responses can cause harm, so compassion must be guided by good judgment. (All virtues require good judgment, as I will argue in the section below on practical wisdom.)

Blum believes the first step in compassion is recognition of someone's suffering, an insight sometimes dependent on the observer's world view.\textsuperscript{14} For example, a physician's conception of the meaning of illness may determine if a patient's suffering is detected.\textsuperscript{15} Consider a patient who has severe chest pain, is rushed by helicopter to our hospital and has a cardiac catheterization procedure and emergency balloon angioplasty to open an obstructed coronary artery. No heart damage occurs, the patient is discharged the next day and has no further heart problems for years. But the experience is emotionally very traumatic. Not only was the patient frightened by the pain and stressed by the helicopter ride, the patient was physically invaded, encountered a strange and frightening place, may fear recurrent emergencies, and may be overwhelmed by the weight of his or her mortality. These patient responses to the problem and treatment of a clogged coronary artery are all part of illness and suffering. If the physician is to be compassionate, the physician must hold that illness has psychological or spiritual features, must understand the nature of those maladies, and have the sensitivity to detect them in the patient. Compassionate
responses are therefore dependent upon the physician’s concept of illness.

It is not easy for physicians to find the appropriate range between total immersion in, and indifference to, patients' suffering. Total immersion in patients' suffering can lead to major errors in medical care. Physicians have to make diagnoses and suggest treatments which may cause patients much additional suffering in order to improve patients' prognoses. If physicians are excessively immersed in their patients' present or potential future suffering, physicians may give inappropriate advice in order to avoid more pain for their patients. This undesirable outcome is most likely due to unconscious processes. For example, consider the case of a long-suffering patient whose test results strongly suggest that a painful procedure is needed to drain an abscess of the lung. The physician is so immersed in the patients' suffering, that the physician cannot bear the possibility of any more pain for the patient. The physician therefore subconsciously denies the evidence indicating the need for the drainage procedure and advises only continued observation. The unfortunate outcome is major additional morbidity for the patient.

Gorovitz notes this need of physicians to avoid the extremes of (1) complete emotional involvement and (2) total emotional distance from their patients. He advises that good physicians must recognize both poles of this problem and
strive to find the right balance. Gorovitz's main point is that if physicians understand the problems of both excessive and insufficient emotional responses to patients' suffering, they can learn the best responses to the plights of patients. That is, physicians have to understand their own responses if they are to develop the virtue of compassion. Gorovitz suspects that unconscious, excessive immersion in patients' suffering may drive doctors to be inhumanely detached to avoid their own pain. As a means of developing compassion, Gorovitz advises a cyclical process of critical reflection and practical involvement in cases. The physician would then work with suffering patients, trying to develop compassion. Physicians would then assess their responses in comparison to the theoretical objectives of compassion. They would try to modify their response on the next occasion."

Warren Reich proposes an intriguing and more complex version of compassion in "Speaking of suffering: A Moral Account of Compassion." Since compassion involves interaction between a sufferer and a compassionate responder, Reich proposes that the suffering, the interaction, and the compassionate response must each be studied. He notes that the Latin root of 'compassion' is best interpreted as "suffering something to happen to oneself" or "to experience" what is happening to the other." Reich defines compassion as the disposition to make others' suffering part of ourselves and to reduce others' suffering. In comparison to simple
pain, suffering includes an existential crisis of search for meaning, shown by questions people ask when they are suffering, such as, "How can I keep my life from being molded and coerced by pain and suffering?" Reich proposes that suffering is the result of, but not the same as, trauma or threat of trauma. Suffering is the mental agony that may come from pain, but it also may involve potential losses such as loss of job and prevention of attainment of one's aspirations.

Reich proposes that the experience of suffering has three phases. (1) "Mute suffering" is the sufferer's inability to communicate the suffering. This is a state of helplessness, in which sufferers lose their autonomy or focus on their life purposes. (2) Sufferers' attempts to understand and to control their suffering through "expressive suffering." They find words which distance the bad experience or they get help from others in developing a new story. For example, it has been noted that burn victims keep telling the story of their injury. It is thought that this retelling plays an essential role in "transforming" their suffering. (3) "New identity in suffering: having a voice of one's own," the final phase, develops from dialogue with a "compassionate other" or others, which provides a caring support system while the sufferer works out a new identity. This evolutionary process from phase one to three involves a move of the sufferer from impersonal language like "lymphoma" (a form of cancer) to more
personal language. In the process there is development of virtues in the sufferer which Reich thinks are not well named, like hope and patience."

Reich proposes that compassion has three phases that correspond to the sufferer's: "silent empathy, silent compassion," "expressive compassion," and "having a compassionate voice of one's own: a new identity." The compassionate responder first silently communes with the sufferer, lending support while the sufferer searches for a voice. The "compassionate other" makes an empathic move of identification with the sufferer without total immersion in the other's suffering. The compassionate responder then helps the sufferer discover language which may confer control, allows expression of emotion, and assists "reformulation of the story." Compassionate others become new persons by "suffering (experiencing) the anguish of the suffering person." Reich also suggests that the compassionate other, as well as the sufferer, gets relief from the anguish of suffering by understanding the meaning of suffering. If compassionate others identify with their new selves, then they are rewriting their own story by their interactions with the sufferer. Reich suggests that this process of reflection on self and corresponding adjustment of one's behavior is akin to Aristotle's development and refinement of virtue as a habit by repeated attempts at the virtue."
Reich argues that medicine's emphasis on objectivity clouds physicians' insight into the worth of closer contact with patients' suffering. He proposes that paternalism inhibits the feeling of commonality with the sufferer that is necessary for compassion. While Reich's proposals are thought-provoking and attractive, important questions arise. How often do patients and caregivers experience the types of responses that Reich postulates? Reich gives no evidence that such processes occur. The time required for these processes would prohibit a caregiver from having compassion when first caring for new patients or for those patients with only temporary suffering. Such an unfortunate outcome does not mean that Reich is wrong. What Reich describes is likely to happen when physicians develop compassion. They repeatedly feel the suffering of others and eventually develop the virtue of compassion, feeling others' suffering to the right degree. Physicians learn appropriate and satisfactory ways to express the suffering they feel in the other, and find helpful ways to respond compassionately. Multiple experiences with patients, if approached in the right way, develop the disposition of compassion. The physician becomes a new person as the habit of compassion is developed.

Howard Brody argues that physicians have impaired capability to respond with Reich's "empathic silence" because of their strong orientation to fix patients' problems. "Fixing" has the connotation of active intervention for
physicians. That is, physicians' are generally impelled to act in response to patients' suffering. Listening often seems too passive to physicians. Listening is "doing" something, but Brody's point is that medical training and practice instill the myth that the physician's job is to do something active for the patient's problems. "Active" means using drugs, doing procedures, ordering tests and so forth. All of these acts are connected in a subconscious, logical chain to the image of fixing patients' problems. Even if unsuccessful, acts that seem connected to fixing problems reinforce the unconscious image physicians have of themselves--of what they should do to fulfill their role expectations. Brody's position agrees with my own observations.

There is considerable emphasis in medical training on making scientific, objective decisions about what is the best advice for patients. Brody, like Reich, suggests that this emphasis on objectivity hinders physicians' development of compassion. The following is the reasoning I understand to be behind the emphasis on objectivity.

(1) Physicians should advise their patients to have those tests and treatments which are most likely to diagnose, heal, reduce, or palliate their illnesses.

(2) Determining the best options for patients requires an unemotional, dispassionate, rational (objective) survey of all reasonable choices.

(3) Some tests, treatments, and diagnoses cause patients to have considerable suffering, such as a diagnosis of cancer, a painful procedure, or chemotherapy.

(4) Compassion causes physicians to feel the present or future pain of patients.
(5) Compassion, therefore, impairs physicians' objectivity.

(6) Physicians, therefore, should be on their guard to avoid excessive compassion in order to maintain objectivity.

This argument for objectivity assumes that suffering is not a central part of illness or that treatment of suffering can be approached separately from treatment of disease. The assumption is that the objective of medicine is to fix the physical problem disturbing the patient and that suffering will go away as the disease or injury is treated. This line of argument about objectivity and its assumptions about the role and treatment of suffering are erroneous for the following reasons.

(1) The objective of medicine is not just to treat diseases, but to heal, prevent or palliate illness, of which diseases are only a component. 23

(2) There is good evidence that most, if not all illnesses are afflictions which include spiritual as well as physical components.

(3) Suffering is usually, if not always, a feature of the spiritual component of illness.

(4) The treatment of illness must, therefore, include the healing or palliation of suffering.

(5) Treatment of the physical pathology of mind and body, such as therapy of a disease, does not necessarily heal or palliate the patient's suffering. Many illnesses, such as a heart attack, have full healing in six weeks, but the patient's suffering may continue for years or a lifetime.

(6) In order to treat suffering, it must first be identified.

(7) Compassion is necessary both for identification of, and appropriate response to suffering. 24
Emphasis on objectivity in medical training, in so far as it promotes indifference to suffering, impairs the development of compassion and hence leads to inadequate medical care.

The American Board of Internal Medicine advises physicians to be "... compassionate and empathic but don't get too involved." Brody asks what data there is to show that too much immersion in patients' suffering has led to serious medical errors.

The cemetery is filled not with the corpses of patients who died because their over-involved physicians became irrational and ineffective, but rather with the corpses of sufferers whose physicians attended to their diseases but failed to heal, because of the multiple characterological barriers that cause physicians not to get close enough.

Brody suggests that "aesthetic distance," quoting Rita Charon, is the best guide for compassion. When aesthetic distance is achieved, the physician would identify with the patient, but would maintain a critical, reflective posture as one would do toward a literary text. This approach might solve the criticism raised by Beauchamp and Childress.

A physician who lacked compassion would generally be viewed as deficient; yet compassion also may cloud judgment and preclude rational and effective responses. Constant contact with suffering can overwhelm and even paralyze a compassionate physician. Hence medical education is designed to inculcate detachment as well as compassion.

Medical training is correct to emphasize the importance of objectivity in weighing evidence and making preliminary decisions about options. But, decisions in medicine must apply not just to diseases, but to illnesses.
must, therefore, come into play. The goal of medical training ought to be to inculcate detachment in so far as it enhances objectivity when needed. It is a mistake for emphasis on objectivity or detachment to lead to indifference.

Brody also suggests that if physicians must develop a habit of being open to patients' suffering, they may need a different attitude toward power. He believes that compassionate responses require acceptance of the power that the sufferer's pain has over physicians. If a physician identifies with a patient's suffering, that physician no longer has as much control in the relationship with the patient. I agree with Brody and his proposal fits with my definition of compassion. The disposition of compassion requires that physicians give up total control of their emotions. They must have some freedom to feel and then identify with a patient's suffering.

CARE

Feelings and actions in response to patients personal needs are the sphere of experience for care. Care is the disposition to be sensitive to personal needs and to act to meet those needs. "Personal needs" are those things we require to live our lives comfortably. Personal needs may be primarily physical or mainly spiritual. Personal needs would include physical comfort, body covering, cheerful atmosphere, pleasant and polite social intercourse, and emotional support. Care includes actions that express concern, show support,
extend warmth, exhibit tenderness, etc. Actions of care might include smiling, holding a patient's hand, listening, hugging a patient, helping a patient carefully to the bathroom, and many other acts that go beyond the mere mechanics of health care. Care includes the disposition to "tune in emotionally" to the needs of patients and respond with actions that meet those needs."

The vices of excess and deficiency in relation to care have no name. "Neglectfulness" may suffice as the vice of deficiency. Physicians who have the vice of neglectfulness do not perceive the need for care or do not perform the actions of care. For example, they might not perceive the importance of making a patient comfortable during a procedure, or they might not act to make the patient comfortable. Such physicians might not assist a patient with a food tray, or be attuned to patients' needs to make themselves more presentable before an interview in the hospital, etc..

The vice of excess with regard to care can be called selflessness in meeting patients' personal needs, in the absence of a specific name. Caregivers with the vice of excess, as with the vice of excess in relation to the virtue of benevolence, deny their own needs to the detriment of themselves. In comparison to physicians with the vice of excess in relation to the virtue of benevolence, who tend to neglect their families, physicians who only have the vice of excess in relation to care tend to meet the needs of their
families as well, but not their own needs. My observation is that this vice is uncommon in physicians, but common in nurses. Physicians primarily have the vice of defect. A serious risk of the vice of excess is professional "burnout." In fact, there are three virtues whose vice of excess may cause burnout--benevolence, care, and diligence. It is likely that these vices reinforce each other.

Compassion and care are different. Compassion is a disposition to sense and to respond to people's suffering. Care is a disposition to sense and to respond to patients' needs before, during, or after their suffering. For example, the patient who is inadequately clothed may suffer from embarrassment. The compassionate response is to cover the patient. The care response would have been to clothe the patient adequately from the outset.

Care and benevolence are both species of the disposition to altruistic acts, but have different substrates. Acts that meet the personal needs of patients are the substrate of care. Acts that heal, prevent, or palliate illness are the sphere of benevolence. This distinction explains how a physician could have the virtue of benevolence without the virtue of care.

The virtue of care has been neglected in physicians' education. Physicians come to medical school with a disposition to care, but their virtue of care is often eroded through professional socialization. Care needs considerable study and emphasis among physicians.
HONESTY

Actions in regard to truth-telling comprise the substrate of honesty. Honesty is the disposition to tell the truth. The vice of deficiency is dishonesty. The vice of excess might be called "brutal candor."

Honesty is a cornerstone of trust in the relations of physicians with patients, families, colleagues, and other health care workers. As I have previously noted, honesty is also a cornerstone of good medical decisions.¹ Physicians with the virtue of honesty can be counted on to tell their patients the truth in ordinary and extraordinary circumstances. For example, they tell their patients the nature and prognosis of their illnesses. If a patient asks such a physician if Dr. "X" is a good physician, the honest doctor will answer that Dr. "X" is a good doctor, or may not be best for the patient because of this or that reason, or is not recommended. As a patient comes to believe a physician is honest, that patient comes to trust that physician. Once patients trust their physicians, those physicians are more able to reassure their patients and patients are more likely to follow their physicians' advice. Patients' trust in their physicians, of course, is also developed by patients' perception of other virtues in their physicians.²

Physicians with the virtue of honesty do not always tell the truth, but they do tell the truth unless there are unusual circumstances. There has been considerable discussion about
the importance of honesty in debates about paternalism versus respect for patients' autonomy. Those favoring paternalism, for example, have argued that doctors often should not tell patients the truth, as it may harm them. Others, in my opinion, convincingly refute these claims. Patients generally need to know the truth so that they can plan their lives accordingly. But, there are some occasions when truth-telling is inappropriate. Suppose an abusive husband asks me if his wife has talked to me about him. If I say yes, he is likely to abuse her. I would obviously not tell him that she had called me and discussed him. But, the habitual response of physicians with the virtue of honesty is to tell the truth, unless their practical wisdom indicates that it should not be told in a particular circumstance. When the truth is told, however, it also matters how it is told.

One difference between the virtue of honesty and what I have called the vice of brutal candor is the "art" of the virtue of honesty. The disposition of honesty includes the habit of telling the truth in the right way and at the right time. Some patients may need the truth told bluntly or all at once. Other patients may need to learn the truth gently and gradually over many conversations. The difference between the virtue of honesty and the vice of brutal candor is also illustrated in what physicians tell their patients about borderline, insignificant abnormalities in test results. Physicians with the vice of "brutal candor" always tell
patients about these borderline results, causing needless worry. Physicians with the virtue of honesty do not worry patients with these borderline test abnormalities unless these results are pertinent to some aspect of the patient's care."

**HUMILITY**

The substrate of humility is attitude toward one's worth in comparison to the worth of others. Humility is the habit of having and maintaining the right amount of self-esteem. The vice of excess is arrogance. The vice of defect might be called submissiveness or meekness. Humble physicians do not deny their own worth, knowledge or competency, but they do not believe they are intrinsically more worthy than patients. Humble physicians are able to assert their beliefs appropriately when others disagree.

The power that physicians have over patients and other health care workers makes humility a very important virtue of physicians. Physicians with the virtue of humility are resistant to the seductions of power. They are more likely to use their power for patients' good and unlikely to abuse power. Since such physicians have less ego need for power, they will respect and maintain the power of patients. They are also less likely to deny their inadequacies and limitations. The virtue of humility reduces the possibility that physicians will psychologically retreat into feelings of omnipotence. Physicians with the virtue of humility are more likely to admit their limitations to themselves, enabling
either efforts to correct their deficiencies or to refer their patients to colleagues with greater expertise.

Humility prepares the ground for care and compassion. For example, arrogance may prevent feeling another's suffering. Arrogance is also antithetical to expressions of care like concern and support. But, the virtue of humility does not prevent assertiveness. Physicians have responsibilities to evaluate and advise patients about their medical problems. Sometimes physicians must be very assertive in making sure that patients hear their advice. Humility involves an circumspect attitude toward power, but this virtue does not preclude appropriate uses of power. The analyses of Cases I, II, and III in Chapter Two and the discussion in Chapter Three provide more detailed examples and discussion of the virtue of humility.

COURAGE

Matters that inspire fear and confidence are the substrate of courage. Aristotle stated that courage "is a mean with respect to fear and confidence." In his view, in respect to fear, courage is the disposition to find the mean between cowardice and absolute fearlessness, which has no name. With respect to confidence, courage is the disposition to find the mean between cowardice and recklessness. Courageous persons feel fear, but their attitude in response to fear is different from others. "A coward, a reckless man, and a courageous man are all concerned with the same
situations, but their attitudes toward them are different."**

Courage leads to acts which may be externally observable or only internally known to the person who is courageous. Consider the example of excellence in practical wisdom. One feature of practical wisdom is excellence in deliberation, which first requires perception of reasonable alternatives. Physicians commonly blind themselves to painful choices or give such choices insufficient weight. The physician with courage, however, endures the fear of bad outcomes from certain choices, keeping fear from unbalancing the factors to be weighed in the deliberation. Courage, therefore, is sometimes essential for intellectual honesty.** Physicians with courage are more likely to admit their uncertainty to themselves and to their patients, preventing retreats into masks of omnipotence or omniscience. I noted in case VI, Chapter Two, that courage supports the work that physicians must do despite the possibility or the presence of physical discomfort.

In former times, working despite the risk of infectious illness was a common way that physicians manifested courage.** Modern Western physicians have not had substantial risk of personal injury from the practice of medicine until the advent of the acquired immunodeficiency syndrome (AIDS).** Although the risk of contracting AIDS is small with proper precautions, accidental transmission of the AIDS virus to physicians may occur in health care work and the virus invariably causes
death. AIDS has made courage a more important virtue for physicians.

CONSCIENTIOUSNESS

Actions in regard to details are the substrate of conscientiousness, which is the disposition to attend to relatively minor items in routine medical practice. The vices might be called carelessness (deficit) and obsessiveness (excess). Excellence in medical practice requires reliable attention to many relatively unimportant details. Examples include the evaluation and reporting of test abnormalities, and the prompt dictation of chart notes and procedure reports. Since each of these tasks is relatively unimportant, failure to complete a particular task does not usually lead to a bad outcome. Frequent failures, however, cause significant defects in physicians' work.

Conscientiousness requires a number of essential skills. Examples are good time management, delegation of tasks, and organization of duties.

PATIENCE

Matters that require time are the substrate of patience. Patience is the disposition to wait, not to be hurried, to accept the time necessary for a task. The activity of patience, in a sense, is inactivity. The vices are impatience (defect) and what might be called immobility (excess). Excellent, humane medical care requires time, time to listen
to patients' stories, to answer questions, to be courteous, considerate and caring. Some patients require much more time than others, sometimes because of the nature of their problems and sometimes because of their communication styles. Physicians with the virtue of patience are able to give these patients the time they need. Such physicians are more able to resist excessive pressures to be efficient and productive.

PERSEVERANCE

Perseverance, in comparison to patience, has a more active connotation. Matters requiring sustained effort are the substrate of perseverance. Perseverance is the habit of persistence in staying at a task, particularly tasks that require extended effort. Perseverance has the connotation of endurance. The term "weak-willed" seems closest to the vice of defect. I have no adequate term for the vice of excess. Physicians with the virtue of perseverance do not easily give up, yet they are not unrelentingly tenacious. The success of some medical procedures and operations requires that the physician have the virtue of perseverance. Some illnesses take persistent effort to diagnose or treat.

DILIGENCE

Diligence is the disposition to work hard. Matters that require significant intensity of effort are the substrate of the virtue of diligence. The vice of defect of diligence is laziness. "Workaholism" is a neologism that comes close to designating the vice of excess. Physicians are prone to the
vice of "workaholism" because hard work is so necessary and highly valued in medical training and practice. It is hard for physicians to develop the balanced disposition toward work which is the virtue of diligence.5

The virtue of diligence is similar, but not the same as the virtue of perseverance. The virtue of perseverance refers more to persistence in staying at a particular task, than to a high intensity of effort applied to the task. A person with the virtue of perseverance could successfully remain at a task with only a moderate level of effort. The person with the virtue of diligence, however, reliably provides a high level of effort.

I noted in Chapter Five that diligence is an essential virtue for learning a practice like medicine. The importance of the virtue of diligence is also evident in any routine medical practice. For example, a physician may have several emergencies over several days, requiring much longer workdays than planned. In another case, complications may require that a surgeon take seven hours for a successful operation instead of the scheduled three hours. That same surgeon may have to get up from bed early the next morning to take care of another emergency.

EQUANIMITY

Attitudes about events that may be troubling are the substrate of equanimity. Equanimity is the disposition to remain untroubled, to be calm in a stormy sea. The physician
with the virtue of equanimity has what William Osler also called "imperturbability."

Imperturbability means coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of great peril, immobility, impassivity, or, to use an old and expressive word, phlegm. Placidity may suffice for the vice of deficiency, implying lack of significant reactivity to circumstances. The vice of excess could be called "excitableness" or "arousableness."

Physicians must often make decisions and act in the midst of chaotic events and patients' life-threatening emergencies, as portrayed in case IV, Chapter Two, of the elderly man in the emergency room. Illness is often associated with very stressful experiences for patients and families. Physicians are usually leaders in medical crises. The virtue of equanimity is very important in all of these circumstances. Good judgments require clear thinking and clear thinking requires "imperturbability." Calm physicians can project their calmness onto patients and families, in essence a form of therapy. Equanimity in physician leaders fosters clear thinking and concentration on tasks by other team members. In contrast, physicians with the vice of "excitableness" agitate other members of the health care team.

JUSTICE

Matters of the distribution of goods and corrections of harms are the substrate for the virtue of justice. Aristotle's view was that
"... all men mean by 'justice' that characteristic which makes them performers of just actions, which makes them act justly, and which makes them wish what is just."¹⁷

Justice is the disposition to be fair, to distribute goods or correct harms according to merit. There is no vice of excess in relation to justice. The vice is all one of defect, which is injustice.

Since physicians are in a pivotal position to control the distribution of vital goods and services to their patients, justice is a critical virtue for physicians. The virtue of justice prevents discrimination against individuals or groups because of race, sex, financial status, age, etc.. Since physicians have such control of the flow of material goods and services that are vital to patients, and since there are so many ways in which subtle unfairness may occur, action-guides cannot effectively guide physicians to be fair. Action-guides can neither practically provide rules for each situation, nor can they provide the motivation to be just. On the other hand, the virtue of justice provides the motivation to be fair. Justice is a complex virtue, as evidenced by Aristotle's extended treatment of it. I am only attempting here to give a superficial overview.

The implications of justice as a virtue are problematic, at least in part, because of uncertainties about the philosophical nature and moral implications of justice as a principle. These uncertainties are evident from the amount of scholarly attention they are receiving.
A person who has practical wisdom, as Aristotle put it, is one who "has the ability to deliberate" about what one should do in a situation when one's actions can effect a change. A person with practical wisdom understands the good and exercises judgment to determine what means will best achieve the good. Practical wisdom is an intellectual virtue that is concerned with deliberation about issues that involve moral virtues. If virtues are, in fact, habits, dispositions, or traits of character, how could practical wisdom affect virtues? One does not decide to be compassionate or thoughtful or friendly. If one has these virtues, one is compassionate, etc., with no choice involved.

Practical wisdom's ability to guide the virtues hinges on the difference between habitual and automatic actions. Automatic actions cannot usually be stopped by the exercise of reason. An example is the automatic or instinctive response of putting out one's hand if one slips on the ice. Reason does not get involved in modifying the automatic response except after the fact. One can determine that the hand should not be put out when one falls and then decide to practice falling while not putting out a hand. With practice, a new automatic response is then instilled. The nature of virtues is not automatic and here the athletic model is again useful. Soccer players execute a series of complex skills while keeping track of the general flow of play. These skills are
ingrained, yet the player can modify the execution of the skills if required by changes in the action. Practical wisdom has this type of relationship with virtues. Persons do not deliberate about whether to exercise a virtue, because virtues are habits. People are honest, courageous and so forth. But virtuous persons' practical wisdom is monitoring their actions and feelings in response to honesty and courage in the instant context. Practical wisdom deliberates about what is necessary to achieve the end to which the virtues are directed and how one virtuous response interacts with other virtuous responses. Practical wisdom then determines what virtuous responses should be followed and in what order.

A common example of the work of practical wisdom in medicine is its role in the interaction of physicians' virtues of compassion, respectfulness, honesty, and benevolence. Consider a patient with a long hospitalization who develops a new complication requiring a risky procedure for treatment, but whose outlook is better with performance of the procedure. The patient has had much suffering and has limited emotional and physical reserves. The virtue of compassion leads the physician to responses which will minimize the patient's suffering. The physician with the virtue of compassion, therefore, may be motivated not even to advise consideration of the new treatment, as it might increase the patient's suffering for the near future. The virtue of respectfulness motivates the physician, on the contrary, to include the
patient in the decision process about the procedure. The virtue of honesty disposes the physician to tell the patient the truth about the need for the procedure and the suffering that will occur from it. The virtue of benevolence would motivate the physician to advise the procedure. Practical wisdom will deliberate about the weights that should be given each of these virtuous responses and determine what should be done and how these responses should be coordinated and enacted. This is an example where the habitual response that is part of a virtue is inhibited by practical wisdom in order that deliberation may occur. Once it is determined what course is best, practical wisdom governs the responses that would be the outcomes of the virtues.

Practical wisdom is developed from experience, but that experience can be of several sorts. Perhaps the best learning comes from observing paradigmatic figures' practical wisdom in action, and from reflecting on one's own life experiences through one's own eyes and those of a teacher. We learn most effectively from teachers who can both demonstrate their practical wisdom in action, and articulate the theoretical bases of their decisions. In the case of medicine, physicians would particularly benefit if their teachers or paradigmatic figures could point out the nature of the virtues in question and the reasoning that led to the final outcome.
Practical wisdom is also developed by our own reflection on our mistakes and successes in practice. Gorovitz suggests that wisdom is best developed through self-conscious reflection on both theory and practice. In medicine, this would mean repeated analysis of one's successes and failures both in terms of practical outcomes and in terms of the theoretical underpinning, which would be the good of medicine. This process of learning practical wisdom takes time, which is why Aristotle said practical wisdom takes maturity.
1. See my arguments about the purposes of medicine and the nature of illness in Chapter Five.

2. See the discussion in Chapter Five.

3. Would a physician with respectfulness be disposed to be respectful to a person guilty of heinous crimes? Yes.

4. See the case analyses in Chapter Two. Also see Chapter Five.

5. A surgeon consulted me about such a case in 1991 when I was chair of the Ethics Committee of the St. Patrick Hospital Medical Staff. The surgeon did support her request not to have surgery.

6. Personal communication from Professor Richard Walton.

7. See the derivation of this virtue in Chapter Five.

8. For example, suppose a mass in the colon is found while a surgeon is operating on an abdominal aortic aneurysm. The surgeon should at least biopsy the mass to determine if it is malignant. It would be negligent for the surgeon not to biopsy it. If the mass were malignant, a more difficult decision would be whether resection of the mass was indicated at the time. This latter decision would depend on the surgeon's assessment of the relative risks of a second surgery in comparison to a very prolonged procedure and increased risk of infection if there was inadequate bowel preparation preoperatively.

   About three years ago a student in a medical ethics class told me of an egregious example of untrustworthiness. She had made an agreement with her doctor to operate on one foot at a time for some type of congenital abnormality so that she could continue her summer job. She awoke with both feet operated upon and was unable to work for the rest of the summer.

9. See the discussions of cases IV, V, and VI in Chapter Two. Obviously, there can be marked differences in the degree of suffering associated with an illness.

10. As noted in the chapter on the history of the virtues in medicine, the Roman physician, Scribonius, thought compassion was a central attribute in medicine which prevented physicians from harming patients. (See Edmund Pellegrino and Alice Pellegrino, "Humanism and Ethics in Roman Medicine: Translation and Commentary on a Text of Scribonius Largus," in Literature and Medicine, D. Heyward Block and Richard M. Ratzan ed. (Baltimore: The Johns Hopkins University Press, 1988), 7:26.) Edmund and Alice Pellegrino believe that compassion is being progressively de-emphasized "as unrealistic and ancillary" among physicians (23). I agree with their views.

12. Benevolence, therefore, is essential for compassion.


14. Virtually everyone would recognize that a person with a broken leg is suffering, but I am thinking of other types of cases as discussed below.

15. See my earlier discussion of the roles of humility and compassion in perceiving the policeman's fear in the discussion of case II, Chapter Two.


18. Reich, 84.

19. Reich, 86. It seems to me that many patients would not be able to articulate such a sophisticated question.

20. Reich, 84-86.


22. Reich, 93-98.

23. Reich, 98.


25. Wrong approaches can lead to lack of compassion—the vice of indifference.


27. See my discussion of concepts of illness in Chapter Five.

28. For example, see case II, Chapter Two.

29. Quoted by Brody, 16.

30. Brody, 16.


34. This discussion of compassion is obviously a more complete effort than the considerations of other virtues in this chapter. I have gone on at length because I have a special interest in compassion and because of the importance of the recent articles to which I have referred.

35. See my discussion of Carse’s essay in the Appendix. (Alisa L. Carse, "The 'Voice of Care': Implications for Bioethical Education," The Journal of Medicine and Philosophy, 16 (1991), 5-28. She points out the importance of the emotions in sensitivity to ethical issues.

36. The common presence of the vice of defect in relation to care is probably tied to different cultural expectations for each gender, and is also tied to differences in doctor and nurse role expectations, which also have gender components.

37. I interpret "burnout" as one example of the many ways this vice may lead to ill health. Other undesirable outcomes might be peptic acid disease, heart palpitations, and other conditions commonly associated with sustained levels of excessive stress.

38. See the discussion on diligence below.


40. See Konner, Reiser and Rosen, and Pence on this issue. (Gregory E. Pence, "Can Compassion Be Taught?" Journal of Medical Ethics, 9 (1983), 189-191.) Pence’s comments about the socialization process in medicine and the importance of the environment for fostering or inhibiting the development of the virtue of compassion are just as pertinent for the virtue of care.

41. Intellectual honesty is essential for making good medical decisions (case VI, Chapter Two) and for learning a practice (Chapter Five). I noted in each case that courage fortifies honesty.

42. Trust is only developed over time, as the patient repeatedly observes the doctor to determine if the doctor truly has the patient’s best interest at heart, is compassionate, caring, trustworthy and so forth.

44. I distinguish this position from paternalism. Paternalism may include withholding significant information from patients. Here I am referring to judgments not to cause unnecessary worry of patients about insignificant abnormalities. One common role of modern physicians is to determine when test results are significant. Borderline test results are extremely common in medicine, because most tests are designed to be normal in only ninety-five percent of the population.

45. I say "unlikely" because it may take great insight to understand the potential of power to do harm. Just as an army tank doesn't notice twigs in its path, physicians may not notice how their power coerces patients to follow their advice. Facing the power of the physicians, patients are intimidated and often do not ask questions to which they would like to know the answers, or patients do not express their misgivings. Similarly, physicians' power may make it difficult for nurses to question physicians' orders.

46. Katz notes the tendencies of physicians to respond to the uncertainty inherent in medical practice with authoritarianism and "the mask of infallibility." He argues that people tend to incorporate these masks into their character, disposing them to be led into images of omnipotence, which they project onto their patients (and their colleagues, I would add). (Jay Katz, *The Silent World of Doctor and Patient* (New York: The Free Press, 1984), 199.)

47. Some patients are so dominating in conversations, for example, that it may be extraordinarily difficult to adequately evaluate their medical problems. In such cases, after giving them a reasonable audience, competent physicians must interrupt these patients and move the activity toward identifying the specific reason they have come. Other patients may be so intellectually and emotionally scattered that they are unable to concentrate for any length of time. Competent, humble physicians must find diplomatic, but effective ways to give them this information and can do so without arrogance.


49. *Nicomachean Ethics*, III,7,1115b6-1116a2.

50. *Nicomachean Ethics*, III,7,1116a4-5.

51. See the discussion about case III, Chapter Two, which illustrated conflicts of interest of physicians when they advise procedures which they perform. Also see the analysis of case IV.


53. In fact, the greatest fear of most modern American physicians may be the fear of litigation.
54. Wallace has a much richer conception of conscientiousness. Under conscientiousness he subsumes several virtues whose general aims are to achieve certain types of behavior. Examples are honesty, fairness and trustworthiness (90). Wallace asks how one sets priorities among conscientiousness virtues and from where does the motivation come to fulfill them? How does one keep from being rigid in conscientiousness virtues' application (93)? Wallace's answer, and I think the right one, is that practical reasoning must be used to set priorities, as all possibilities can never be covered by rules (119). See my discussion on practical wisdom in the text below. James D. Wallace, Virtues and Vices (Ithaca: Cornell, 1978).

There are a number of skills which are required for each virtue. I have omitted discussion of most of those skills to keep this effort within reasonable constraints.

55. See my discussion of my own training in Chapter One.


57. Nicomachean Ethics, V,1,1129a6–9.

58. Nicomachean Ethics, VI,5,1140a31, VI,7,1141b8–13.

59. Nicomachean Ethics, VI,5,1140a30.

60. See Chapter Four on the nature of the virtues.


63. See the discussion above on compassion.

CHAPTER SEVEN
Some Criticisms of Virtue Theories

This chapter represents a preliminary consideration of a few criticisms of virtue ethics. I first discuss a critique based on claims about moral pluralism. I then examine several arguments voiced by Robert Veatch.

Moral Pluralism

It is argued that the presence of moral pluralism eliminates the possibility of a valid virtue theory. I understand the argument to be as follows.

(a) A virtue theory must rest upon a concept of the good (as I have argued above).

(b) Moral pluralism is a fact in our country.

(c) Moral pluralism is a state of disagreement about what is good. That is, at least two groups which constitute a significant portion of the population have different moral beliefs.

(d) Therefore there can be no general agreement about what is good.

(e) A valid virtue theory is, therefore, not possible in our country.

There are at least two points in this argument which can be questioned. Moral pluralism is thought to exist in our multicultural society, but what would be adequate empirical data to prove moral pluralism's existence? Such a study would first require sufficient criteria for determining that there
are significant differences between the moral beliefs of two groups that comprise a significant portion of the population. Even if moral pluralism were found to exist, what would be the criteria for determining that different groups' beliefs are so incompatible that the groups could not develop a general concept of the good? I do not believe the answers to either of these questions is known. Since I cannot resolve these questions about moral pluralism in this essay, however, and since the existence and above implications of moral pluralism are commonly asserted by philosophers, I will accept the possibility that moral pluralism exists and that its existence precludes sufficient agreement about the good.¹ Granting these assumptions and the argument that there cannot, therefore, be a valid virtue theory in our country, a valid virtue theory can still be developed for medicine.

I have argued that the goods of medicine can be developed from the goods of professions and the purposes of medicine.¹ If the moral pluralism argument stated above is used against a virtue theory for medicine, it would have to be shown that there is irreconcilable disagreement among physicians about the goods of medicine. I am aware of no evidence of such disagreement. There are differences of opinion about the narrowness or broadness of definitions of illness, as I have discussed, but none to the degree that the meaning of compassion, benevolence, courage and so forth are significantly altered. At least in American medicine, there
is much more agreement than disagreement about the purposes of medicine and the nature of illness. The disagreements are primarily about peripheral issues.

The same virtues may have different implications, depending on a physician's concept of the nature and purposes of medicine or of illness. For example, one can easily imagine cases where differences in moral beliefs might alter physicians' health care decisions. Moral pluralism will be reflected in disagreements among physicians about the importance of preservation of life, the appropriateness of withdrawing food and water in patients in chronic vegetative states, the rights of the elderly to unlimited health care, and so forth. These disagreements must be solved through analysis of principles and rights and nonvirtue theories. Such disagreements will be reflected in discussions about what are the proper goals or objects in medicine of benevolence. But, physicians will still need the virtue of benevolence, just as they will need courage, compassion and so forth. Moral pluralism may cause some philosophical differences in medicine, but the content and list of the virtues will not be drastically altered. I take up a similar argument below in response to Robert Veatch's second criticism of virtues in medicine.

Robert Veatch's Critique

Robert Veatch gives a lengthy critique of virtues in medicine in his essay, "Against Virtues: A Deontological
Critique of Virtue Theory in Medical Ethics. As Veatch makes some strident rebuttals to virtue theories or claims to the importance of virtues for physicians, and since the work seems to have been quite influential, I will examine his essay at some length. He defines virtues as a set of character traits which are praised in general or praised for a particular role. In contrast to acts, Veatch limits the use of the term [virtue] to character, inclinations of the will, persistent motivation, those qualities that make human actions praiseworthy or blameworthy, not right or wrong. Veatch explains that he cannot allow right conduct or acts to be part of virtues if he is to offer a deontological critique of virtues. He states that his virtue definition is now standard in the literature of philosophical ethics, citing Beauchamp, among others. In the same volume as Veatch's article, however, Beauchamp refutes any notion that virtues do not include actions, noting that "as Aristotle repeatedly says, virtue is integrally tied to action that ought to be performed." "Virtues are dispositions to do what persons ought to do as a matter of duty." I previously claimed that virtues are dispositions to feel or to act, following Aristotle. Compassion and care, for example, have features both of feelings and action. We think of courage as the disposition to act courageously, although for an act to be virtuous, the person must also have courage.
Veatch's attempt to separate conduct from virtue is thus problematic at the outset.

Veatch defines a virtue theory as a "systematic formulation" of virtues. He concludes that there are four significant problems for virtues in medicine. The first problem is "that the proper virtue set is not obvious." He notes the variable lists of the virtues in the history of medicine. He comments that it has been known since Plato that different roles (warrior, philosopher) require different virtues (courage, wisdom). Since medicine includes the roles of doctor, nurse, social worker, etc., Veatch concludes that it will be complex job to develop a virtue theory that describes the virtues for all these roles. Hence, the proper virtue set is not obvious. This is a problem for medicine, but a problem only in the sense that it is a job that must be done. This thesis, in part, is an attempt to develop the virtues of physicians. The work of determining the virtues for all roles in medicine is only a problem in that the job may be complex and lengthy, but not practically impossible. This practical problem does not impugn the theoretical merit of the virtues and I think this thesis effort demonstrates that it is not a prohibitively complex task.

The second problem is "that the proper set of virtues for a particular role is not obvious." Veatch is concerned that it may be hard to define medicine as a practice, in part because there may be "several radically different, competing
images of the role" such as the images of an "Orthodox Jewish practitioner" or a "feminist health collective staff physician." This argument has some similarities to the concerns raised above in relation to moral pluralism. Veatch's point is that since each of these doctors may have a different perception of the nature of medical practice, there may be different sets of virtues that correspond with each perception.

Even a role as specific as that of physician may in fact really be countless roles, each with its own set of virtues. The selection of the particular description of the role (and therefore the virtues that attach to it) can never be a philosophically neutral task. One will have to make important normative judgments before the type of physician role can be formulated."

I agree that the implications of both moral principles and virtues for medicine are dependent on what practitioners consider to be their roles. Determination of their roles is dependent on what physicians think are the purposes of medicine and their basic assumptions, such as the meaning of illness. For example, physicians would likely agree that the purposes of medicine, as previously defined, are to prevent, heal or palliate illness or some similar definition. Yet physicians might differ about what are illnesses. Consider the case of a patient who has prolonged and major emotional distress in response to a disabling injury. Some physicians might consider such psychological problems as nonillness, hence outside the province of medicine, or as nonlegitimate illness. In such cases, benevolence would not guide the
physician to try to heal the patient's spiritual problems because they would not be considered proper subjects of medicine. Such a physician's compassion might also not respond to the patient's emotional suffering because the physician does not identify the suffering.

Although the implications of the virtues may vary, depending on practitioners' interpretation of the nuances of illness, the core set of virtues for physicians can likely be agreed upon. Most physicians can sufficiently agree about the nature and purposes of medicine to derive the virtues of compassion, caring, benevolence, trustworthiness, and the other virtues discussed in the first section of this chapter, regardless of fine distinctions about the purposes of medicine. As long as it is accepted that medicine is concerned with illness, and that illness is associated with suffering, that the training of physicians takes long, hard work, etc., as I have already argued, the virtues are then essential. Veatch's second point is that "the proper set of virtues for a particular role is not obvious." They may not be obvious, but they can be determined.

Veatch's third criticism is that emphasis on virtues can lead to wrong acts by physicians. He proposes a hypothetical situation where benevolence is the only virtue. Physicians in such a case, he thinks, would believe so strongly that they understood what is good for their patients, that they would avoid monitoring by their peers or the public, and the public
might not be inclined to regulate physicians' conduct. As evidence, Veatch cites examples of inappropriate conduct by researchers who were doing their work for patients' good. This is a poor example because virtues never exist in isolation from other virtues or a philosophical foundation. Veatch pointed out earlier in his essay that virtues never exist in a philosophical vacuum, but he then creates one to prove the case against virtues. The outcomes of benevolence are dependent not just on the habit of doing good for patients, but also on physicians' respectfulness and humility. If benevolent physicians respect patients as independent, rational beings and if humility keeps physicians from unconsciously controlling patients, then benevolence does not result in the egregious paternalism that Veatch envisions.

Veatch then argues that since there is such opportunity for abuse of virtues even when there is only one virtue, the outcome would be worse when there are multiple virtues.

Given the enormous variety of virtues and the lack of any systematic methods of resolving conflicts over which moral virtues should be included in a proper virtue set together with the earlier problem of slippage between virtuous intention and doing the right thing, the probability of right conduct resulting from a general promotion of virtuous character is not great. Looked at from the subjective perspective of a lay person in a health care setting, the probability of a health professional doing what the patient considers to be correct, simply because the professional has developed a virtue-centered approach to ethics, is infinitesimal. Both lay person and professional have an enormous range of virtues from which to choose. Getting them to pair up in a random pairing in a secular, modern medical facility is very unlikely.
A "systematic set" of virtues, however, would counter these arguments of Veatch's. A "systematic set" would be coordinated and nonrandom. Conflicts among virtues would certainly arise and some conflicts would be solved by practical wisdom. Veatch poses his argument as if all moral issues in medicine were to be covered by a system of virtues. Some conflicts may require reflection on rights, principles or duties for resolution and I am not asserting that virtues can solve all moral problems.

Veatch claims that physicians' and patients' virtues should match. He does not explain why such a match is essential and I argue that a match is not required, at least for the set of virtues I developed above. Consider the extreme disparity of virtues in the case where a physician has to treat a murderer who is in pain. The physician may despise the murderer, but the compassionate physician will still find it possible to feel the murderer's suffering and be motivated to provide relief of the pain. The conscientious physician will provide this patient necessary services with the usual competence.

Veatch points out that much of modern urban medicine is "stranger medicine" in which physician and patient neither know each other, nor share values upon which they will make health care decisions. In his fourth criticism, Veatch argues that "virtue theory is unnecessary in stranger medicine." When strangers enter an urban hospital, he says,
they are more concerned that physicians do the right thing, rather than that their doctors "act with the right motive.""\textsuperscript{13}

I think it can be reasonably said that in the world of strangers, we are much more concerned about conduct than virtuous character. If we could be assured that the physician would do the right thing, we would not really be concerned about motivation. At best, a concern about virtuous character is a concern that virtue will be instrumental in producing right conduct. . . . Virtuous character in the world of stranger medicine is at best a luxury and at worst a deterrent to right conduct. The problem is particularly acute in the world of strangers since there is no reasonable basis for assuming that the stranger with whom one is randomly paired in the emergency room will hold the same theory of virtues as oneself."

It would be absurd to argue that patients would ever want anything but right conduct by their physicians. Veatch can only use this point as an argument against virtues because he has excluded action from virtue. Even if virtues were only psychological traits, they would still be crucial for physicians conduct, not ". . . at best a luxury and at worst a deterrent to right conduct."\textsuperscript{15} As I argued at length in the sections on the specific virtues and earlier in this section, appropriate acts of physicians are often dependent on virtues.

Veatch argues that strangers in a community hospital or a specialist's office have the least need for virtues in physicians, but I assert that strangers have the greatest needs for virtuous physicians. In comparison to community hospitals, the hospital environment is particularly alien and frightening for strangers. What persons could have greater
requirements for compassionate and caring physicians? Veatch argues that what is key is for the physicians to act as if they had compassion and care, not to have these virtues. My discussion of these virtues above established that physicians cannot understand what acts are compassionate and caring without the corresponding virtues. Veatch argues that principles can give guidelines for such acts, but in this situation principles cannot inform acts in the ways that virtues can.
NOTES

1. See my discussion about universal good in endnote 4, Chapter Five.

2. See Chapter Five.


4. It is the only fairly thorough attempt at rebuttal of virtues in medicine that I have encountered and is commonly cited. For a commentary on Veatch's essay and his reply, see Daniel A. Putman's "Virtue and the Practice of Modern Medicine," The Journal of Medicine and Philosophy, 13 (1988), 433-443. Robert Veatch replies to Putman in the same issue in "The Danger of Virtue," 445-446.


7. Veatch, Note 2, 343-344.

8. The Beauchamp citation is from Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics, 2d ed. (Oxford: Oxford University Press, 1983).


10. Chapter Four.


12. Veatch, 331.

13. See my discussion of the history in Chapter One.


15. Veatch, 333.


17. Veatch, 335-36.


19. See my discussion of practical wisdom in the previous chapter.


CHAPTER EIGHT

Summary, Conclusions and Future Directions

There is no doubt that virtues are essential for physicians. Evidence for this claim was first developed in this thesis from the history of the virtues in medicine. The virtues have always been thought by some physicians to be essential. Scribonius Largus, of ancient Rome, and John Gregory, of the eighteenth century, each held that virtues were the foundations of excellent medicine. It is not clear how extensively the virtues have been taught to physicians or practiced by them over the centuries. Attention to physicians' virtues has probably undergone a progressive decline since about 1800. Physicians learn some virtues in their training, but I have found no evidence that medical educators either have a well-formulated concept of virtues, or that they have given the virtues a formal place in medical curricula. In fact, some vices are often taught. As with the virtues, the vices are probably not articulated, but are either modelled by faculty, or are the inevitable outcome in many physicians from their adverse experiences in medical training. Examples of vices which are taught include indifference, instead of the virtue of compassion; neglectfulness, instead of the virtue of care; and arrogance,
instead of the virtue of humility. Just like the virtues, the vices appear to be taught by example.

Strong evidence for the importance of the virtues of physicians was then developed from analyses of six medical case histories from my own experience. For example, the virtues of humility and compassion are essential for the diagnosis and treatment of some patients' problems. Action-guides, derived from ethical principles, cannot supplant the virtues. Adequate moral deliberation about principles sometimes cannot occur without the virtues. One case analysis showed that the virtues of justice, honesty, and humility may be necessary to mitigate inappropriate outcomes from physicians' conflicts of interests. In another case, the virtues of patience, perseverance, and equanimity were essential to carry out the implications of the principle of beneficence. It was pointed out that the need for virtues may be shown by action-guides, but the virtues themselves are not derivable from action-guides. It was demonstrated that motivation of physicians is important, and it is provided by virtues. But, motivation is not provided by moral principles.

It is one thing to demonstrate that physicians' virtues are essential, but it is quite another to show that an adequate virtue theory can be developed for medicine. That task is clearly beyond the scope of this effort. The remainder of this thesis, therefore, was a first attempt at developing the components of a virtue theory for medicine. To
that end, I first suggested that a virtue theory has two bases, a moral psychology and a concept of the good. For the former, I adhered to Aristotle’s concept that virtues are certain sorts of character traits, or dispositions to feel or to act, which are habits learned through practice. I explained his concept that each virtue is a mean with respect to the vices of excess and deficiency. Each virtue and the corresponding vices are concerned with a specific substrate. To further explain the nature of virtues, I showed their similarities to the nature of the acquisition, retention, and execution of soccer skills. It was explained that the virtues are habits which are ingrained or automatic in the sense that a person does not have to go through a struggle of will every time an occasion for virtues arises. The moral virtues always function in conjunction with the intellectual virtue of practical wisdom, which monitors them. Since the potential outcomes of virtues may conflict in a particular case, practical wisdom sometimes must limit or set priorities among the virtues. A comprehensive review and analysis of contemporary literature on virtues would be necessary for a more fully developed work, but that task was not attempted here.

I then argued that a virtue theory for medicine can be based in the good of medicine. I proposed that the good of medicine can be derived from the more general good of professions. Edmund Pellegrino’s six characteristics of
professions, based in their relationships with clients, were therefore analyzed. My review supported his conclusion that professions have irrevocable moral features based in their relationships with clients. I agreed with his argument that the primary claim of professions is that they have knowledge that will be used to benefit clients. I concluded that the chief or final good of professions, and hence of medicine, is the benefit of clients or patients. I argued that the virtues of physicians could then be derived from the good of medicine, when it was clarified by assessment of the purposes of medicine, the nature of medical practice, and patients' experience of illness. I agreed with Pellegrino that these six characteristics of professions yielded the primary virtues of benevolence and trustworthiness for professionals. I suggested that respectfulness is also derivable from the characteristics, and is necessary to counterbalance paternalistic implications of benevolence. It was suggested that the remainder of physicians' virtues could then be derived from the good of medicine. These virtues were compassion, care, honesty, humility, courage, conscientiousness, patience, perseverance, diligence, equanimity, and justice. Each virtue was defined according to a strategy modelled after Aristotle's approach. (1) The substrate of action or feeling was identified. (2) The vices of excess and deficiency were established. (3) The virtue was defined with respect to (1) and (2). Each virtue
was then discussed, including some relevant examples. The following summarizes the structure of each virtue.

Benevolence
Substrate: Management of medicine's resources in regard to patients' illnesses. Those resources include the skills, knowledge and time of physicians.
Definition: The disposition to use the resources of medicine to help patients by preventing, healing, or palliating their illnesses.
Vices (deficiency/excess): Selfishness (using medicine's resources primarily to benefit oneself)/ Selflessness in regard to use of medicine's resources acts to prevent, heal, or palliate illness (no name).

Respectfulness
Substrate: Attitudes and actions with regard to the worth or dignity of patients as persons.
Definition: The disposition of having respect for persons.
Vices (deficiency/excess): "Disrespectfulness"/No sufficient term ('fawning' or 'sycophancy' or 'obsequiousness' come close).

Trustworthiness
Substrate: Actions in regard to promises.
Definition: The disposition to keep promises or to be faithful to commitments.
Vices (deficiency/excess): Untrustworthiness /"Blind adherence to the letter of a promise" (no name).

Compassion
Substrate: Feelings and actions in response to the suffering of others.
Definition: The habit of feeling others' suffering as one's own and of responding to reduce others' suffering.
Vices (deficiency/excess): Indifference/Total immersion in others' suffering (no name).
Care
Substrate: Feelings and actions in response to patients personal needs.
Definition: The disposition to be sensitive to personal needs and to act to meet those needs.
Vices (deficiency/excess): "Neglectfulness"/Selflessness in meeting patients personal needs (no name).

Honesty
Substrate: Actions in regard to truth-telling.
Definition: The disposition to tell the truth.
Vices (deficiency/excess): Dishonesty/"Brutal candor."

Humility
Substrate: Attitude towards one's worth in comparison to the worth of others.
Definition: The habit of having and maintaining the right amount of self-esteem.
Vices (deficiency/excess): Submissiveness or weakness/Arrogance.

Courage
Substrate: Matters that inspire fear and confidence.
Definition: In respect to fear, courage is the disposition to find the mean between cowardice and absolute fearfulness, which has no name. With respect to confidence, courage is the disposition to find the mean between cowardice and recklessness.
Vices (deficiency/excess): (See above).

Conscientiousness
Substrate: Actions in regard to details.
Definition: The disposition to attend to relatively minor details of routine medical practice.
Vices (deficiency/excess): Carelessness/Obsessiveness.

Patience
Substrate: Matters that require time.
Definition: The disposition to wait, not to be hurried.
Vices (deficiency/excess): Impatience/Immobility.
Perseverance
Substrate: Matters requiring sustained effort.
Definition: The habit of persistence in staying at a task.
Vices (deficiency/excess): "Weak-willed"/No name.

Diligence
Substrate: Matters requiring significant intensity of effort
Definition: The disposition to work hard.
Vices (deficiency/excess): Laziness/"Workaholism."

Equanimity
Substrate: Attitudes about events that may be troubling.
Definition: The disposition to remain untroubled.
Vices (deficiency/excess): Placidity/
"Excitableness" or "arousableness."

Justice
Substrate: Distribution of goods and corrections of harms.
Definition: The disposition to be fair.
Vices (deficiency/excess): Injustice/no vice of excess.

Practical Wisdom
Practical wisdom is an intellectual virtue, not a moral virtue. A person with practical wisdom understands the good and exercises judgment to determine what means will best serve the good. To that end, practical wisdom monitors the virtues and determines their priorities, if they conflict, in a given situation. Practical wisdom is learned from experience, including observation of paradigmatic figures and self-conscious reflection on both theory and practice.

The thesis then presents a brief discussion of some criticisms of virtue theories. The argument based in moral pluralism, as I understand it, holds that moral pluralism exists and is an unsurmountable obstacle for a general virtue theory because moral pluralism prevents discovery of the chief good. Although noting that some empirical data and
philosophical investigation would be necessary to prove that moral pluralism exists and that it precludes identification of the good, I do not attempt to refute the argument in relation to a general virtue theory. Some arguments are then given to suggest that a virtue theory for medicine, based in the chief good of medicine, may yield a set of virtues which are not significantly affected by moral pluralism. I agree that moral pluralism will result in some philosophical differences in medicine, but argue that there is sufficient agreement among physicians about the nature and purposes of medicine to develop a set of physicians' virtues. I also argue that the nature of a virtue such as compassion will not change, although philosophical differences among physicians might vary what is identified as an object of compassion. Moral pluralism poses serious problems for any virtue theory. It needs much more consideration. The argument against virtues based on moral pluralism is a very serious one. What I have presented is only a very preliminary consideration of this issue.

Some of Robert Veatch's criticisms about virtues in medicine are similar to those arguments about the implications of moral pluralism for a general virtue theory. Veatch argues that physicians from different backgrounds will have different conceptions of physicians' roles and, hence, different lists of the virtues. My response is similar to that given in rebuttal to the moral pluralism argument. Veatch then uses a
hypothetical case to argue that a virtue emphasis will lead to wrong acts by physicians. In the case, benevolence is the only virtue. I argue that this example has no relevance to ordinary circumstances, as it does not allow counterbalancing of benevolence by other virtues. I argued elsewhere that the virtue of respectfulness is necessary to oppose potential paternalistic outcomes of the virtue of benevolence. Veatch's final argument is that virtues are unnecessary in "stranger medicine," in which physician and patient neither know each other, nor share values. He asserts that patients are much more interested in having their physicians do the right acts then in their having the right character. Veatch can make this assertion because he has defined virtues as character traits which do not include dispositions to action. I respond that it would be absurd for patients not to want the right acts from their physicians, noting my previous arguments that appropriate acts of physicians are often dependent upon virtues. I argue that patients who are strangers in a particular health care environment have the greatest needs for virtues like compassion and care in their physicians. I noted that my previous arguments showed that physicians cannot know what acts are caring and compassionate without the corresponding virtues.
CONCLUSIONS

Virtues are essential for physicians in medical practice. A virtue theory for medicine is yet to be developed. This thesis presents the rudiments of that project.

THE FUTURE AND VIRTUES IN MEDICINE

Future work toward developing an adequate virtue theory for medicine should obviously include a thorough review of contemporary scholarship in the virtues, followed by reconsideration of Aristotle's moral psychology. The obstacles raised by moral pluralism need serious study. This work should be buttressed by a more thorough investigation of the history of virtues in medicine and the current roles of virtues among physicians.

Much work is needed to determine how best to teach the virtues. This objective would require an assessment of the current teaching of virtues in medicine. Various means of teaching virtues should be tried and evaluated. The best means of teaching virtues from paradigmatic figures should be studied. Their educational potential, both as direct role models and as biographical figures, needs exploration. The most effective means of mentoring needs investigation.¹

Medical faculty must agree that the virtues need greater emphasis. This will not be easy as medical faculty are very resistant to change. Medical faculty themselves will need more education about the virtues—what they are and how to
teach them. A prerequisite to teaching the virtues effectively is the elimination of the abuse of medical students and postgraduate physicians.
NOTES

1. See Chapters Five and Six.

2. The issue of mentoring is getting some attention. For example, see "Professionalism in Residency," by F. Preston Reynolds, M.D., Annals of Internal Medicine, 114 (1991), 91-92.

Moral theories can be divided into the deontological and the teleological.¹ Teleological theories, such as virtue theories and utilitarianism, hold that the purpose of the moral life ultimately is "the good." "The good" is the chief, most important or supreme good, toward which the moral life should be directed. Teleological theories may be differentiated from one another by their conceptions of "the good," or by how "the good" is achieved. "The good" of utilitarianism, for example, has been construed as happiness or pleasure.² A utilitarian's moral obligation, according to the "principle of utility," is to act to produce the greatest happiness or pleasure. The right actions produce (or should produce) the greatest, or at least the same net good over evil as any other acts.³ Although a virtue theory may also consider happiness "the good," in a virtues approach, the good is reached in an entirely different fashion than in utilitarian theories, as discussed later in this thesis.⁴

Deontological theories hold that the basis of moral obligation is the right. Moral agents should do what is right, regardless of the consequences of their actions.⁵
Sources of the right for deontological theories include divine law, intuition and common sense, natural laws and rights, and a Rawlsian "hypothetical social contract."

G.E.M. Anscombe has argued that in the absence of any widely accepted source of a general moral law, such as divine law, it may not be possible to derive a moral 'ought' for deontological theories. Similarly, Richard Taylor argues that concepts of moral right, wrong and obligation can only be justified by underlying principles which have the status of laws, but no such laws are universally accepted by philosophers. He concludes that philosophical ethics should instead be concerned with virtues, since they may be a more justifiable source for the moral life.

Moral theories may also be differentiated by their agent or act emphasis and by the means of promulgation. If the emphasis is on agents, the theory is especially concerned with what sort of person one ought to be. If the emphasis is on acts, the stress is on what a person does. Moral knowledge may be promulgated by rules or paradigms. Rules are guidelines which moral agents can apply to a particular case to decide what is right to do. Alternatively, the theory may hold that moral wisdom is best promulgated through the study of paradigms such as Jesus or Socrates. Promulgation through paradigms can have an act or agent emphasis. Persons can focus on trying to be the same sort of person as the paradigmatic person or act as the paradigmatic person would.
An agent who was trying to be the same sort of person as the paradigmatic figure might try to incorporate the figure's beliefs, wisdom and means of solving problems. In an act paradigm emphasis, the agent might try to emulate acts of the paradigmatic person.

In contrast to this general framework of moral theories and concepts, bioethics literature has often focused on investigating and fostering what Baruch Brody calls "mid-level principles," relatively abstract, general guidelines for moral choices in medical practice which seem unrelated to one of the overarching theories. The authors instead concentrate on investigating the ordering and implications of these "mid-level" principles." Beauchamp and Childress claim in *Principles of Biomedical Ethics*, their widely used textbook of biomedical ethics, that "a well-developed ethical theory provides a framework of principles within which an agent can determine morally appropriate actions" (emphasis mine)." The emphasis in the literature is on guidelines for acts, not considerations of moral agents, in contrast to the emphasis on moral agents that is characteristic of a virtue theory. Among others, respect for autonomy, beneficence, justice, and nonmaleficence are ethical principles held to be sufficient for most moral choices in biomedical ethics, although it is admitted that there are cases where conflicts between principles do not lend themselves to a clear resolution."
Clouser and Gert have recently criticized "principlism," a view they ascribe to Beauchamp, Childress, and others. By "principlism," they mean philosophers' use of the principles of justice, respect for autonomy, beneficence and nonmaleficence as if these principles were derived from a coherent ethical theory. Clouser and Gert argue that no such theory has been demonstrated. Beneficence, for example, can have different interpretations depending on the theory from which it is derived. Beauchamp and Childress claim that theories flow through to principles and specific moral judgments are ultimately derived from moral theories. Clouser and Gert argue that this hierarchical relationship has not been shown and has not been demonstrated to lead to action-guides. For example, they claim that Beauchamp and Childress' principle of justice, discussed in Principles of Biomedical Ethics, contains "not even a glimmer of a usable guide to action." Clouser and Gert conclude that "principlism" represents an incoherent combination of utilitarianism and deontology and does not represent an adequate moral theory.

Jonsen and Toulmin have another solution to the problems they see with present moral philosophy: casuistry. In The Abuse of Casuistry: A History of Moral Reasoning, they seek to revive the method of casuistry. Casuistry is a technique of moral reasoning which develops maxims from paradigmatic cases, and then attempts to apply the maxims to other cases by
analogy with the paradigmatic cases. These maxims are not rigid, for cases may be so different from any paradigmatic cases that they require new maxims.' The strategy of the casuist is to start with definite, paradigmatic cases from which a particular principle or maxim has been derived. To determine how the maxims should be applied in a different sort of case, the casuist starts with cases most similar to the paradigmatic case and sequentially works through cases less and less similar. The idea is that the gradual progression to more dissimilar cases will maintain the link to the paradigmatic case, allowing appropriate decisions in most cases. This strategy only goes so far. As Aquinas stated, general principles cannot be applied in the same way everywhere because of "the mutability of human nature, the diverse conditions of persons and their affairs and the differences of time and place." New developments may indicate the need for new maxims, a situation not uncommon in medicine. Moral wisdom for a casuist is then the ability to determine how to apply maxims in specific cases and to know when the maxims do not apply. To develop this practical wisdom, which Jonsen and Toulmin believe is the type of practical reason that is just what Aristotle meant by phronesis, moral agents must be reflective, informed and experienced."

As John Arras understands them, Jonsen and Toulmin conceive that the "new casuistry" is not an instrument for the
The proper and best application of abstract principles, but principles are instead derived from groups of cases and are modifiable if new facts arise. Arras thinks they show some ambiguity about the origin of principles, as Jonsen and Toulmin sometimes propose that principles evolve from general beliefs in the culture and at other times are born from particular cases. But the interpretation of what is of moral significance in a case is always tied to a culture's conceptions and traditions. Even in "routine" medical practice cases, societal concerns and emphases change and new insights develop, requiring that casuistry, or other theories, stay attuned to values and concepts in the greater society. Casuistry, therefore, must not be too bound to specific medical cases, as it would be blind to larger currents and concepts in the society. Arras does not see how casuistry can hope to solve societal problems, such as distributive justice issues, about which there is widespread disagreement, without trying to formulate general principles. But all theories are subject to conventions and assumptions in society. If any theory is to remain viable, whether deontological, casuist or virtue, philosophical reflection must continue to consider basic societal assumptions, such as those implicit in gender bias and unconscious discrimination against minorities. New insights must be reflected in modification of the theory.

Another recent approach to ethics, called the "care orientation," criticizes both principles-based approaches and
casuistry. In her recent essay, "The 'Voice of Care': Implications for Bioethical Education," Alisa Carse outlines the differences between the standard, principles-based approach and the care orientation. She then draws implications for both the process and the content of moral reasoning. Carse notes two major orientations in morality: the "justice orientation," which emphasizes impartiality, individual rights and dispassionate choices, and the more recent "care orientation," which stresses our existence in relationships. Moral agents, depending on their orientation, will emphasize either impartial justifications or concern with the context of a specific case. Whether one is concerned with application of abstract principles or works from the care orientation, in applied moral reasoning one always starts with a specific case. The difference, Carse contends, is the role that the case has in moral reasoning.

If one is oriented to emphasize abstract principles, one attempts to step back from the case to make a judgment, although one must be sensitive to the details of the particular case. The care orientation might then be thought to be in service of a principles-based approach, the care orientation increasing one's sensitivity in a case to the issues stemming from relationships. But Carse's point is that there are moral capacities, separate from an understanding of principles, that are necessary to understand the moral content and to give moral guidance in a particular case.
example, "to be kind is, among other things, to be capable of interpreting when a situation is one in which kindness is called for and what being kind amounts to in that situation." In the care orientation, moral judgments require that the agent be sensitive not just to the facts and context of the case, but also to people's feelings, their reactions to the situation and to the agent's relationship with them.

"This attention, and the discernment of particulars it involves, is itself a moral capacity which can be developed and exercised with greater or lesser success and which, crucially, is not itself principle-governed." 31

Carse does not fully succeed in making a clear distinction between a principles-based, "impartial" approach and the care orientation, but I think she does succeed in suggesting that there is a difference in emphasis in the two orientations. The principles-based approach stresses rational, impartial decisions, keeping the case in mind. The care orientation emphasizes that the particularities of the case must be kept central and that our relationships with others are of primary importance. The care orientation, as outlined by Carse, does not dismiss principles, but the role of principles is to be rough guides for the case, while one stays closely attuned to the relationship issues of the case. It is the latter emphasis which, I think, distinguishes the care orientation from casuistry. Casuistry develops maxims from paradigmatic cases, and then reasons from them to other
cases by analogy, keeping the paradigm strongly in mind. The care orientation, however, maintains that it is the relationship issues of the instant case which are most important, with maxims aiding in interpreting that case.

The care orientation, Carse argues, establishes an important role for virtues in normative ethics. For example, if relationships are central in determining both the moral content and analysis of a particular case, then virtues like compassion are crucial, as they focus on the needs of a particular person. In contrast, the principle of beneficence emphasizes the general love of humanity. If virtues like compassion and caring are central, and if community with others has a primary role in determining moral content, then interpersonal or communication skills become crucial in one's moral repertoire.

The care orientation may have some very strong arguments for the importance of virtues. It would be very interesting to consider these implications of the care orientation, but this effort is beyond the scope of this thesis.
NOTES


3. Frankena, 34.

4. Particularly see Chapter Five for the role of "the good" in a virtue theory.


9. Professor Richard Walton has advanced the concepts in this paragraph.


26. Arras, 43.


29. Carse, 11-12.

30. Carse, 11-12.

31. Carse, 12.

32. Carse, 19.