Virtuous acts as practical medical ethics: an empirical study

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Abstract

Rationale, aims and objectives   To examine the nature, scope and significance of virtues in the biographies of medical practitioners and to determine what kind of virtues are at play in their ethical behaviour and reflection.

Methods   A case study involving 19 medical practitioners associated with the Sydney Medical School, using semi-structured narrative interviews. Narrative data were analysed using dialectical empiricism, constant comparison and iterative reformulation of research questions.

Results   Participants represented virtuous acts as centrally important in their moral assessments of both themselves and others. Acts appeared to be contextually virtuous, rather than expressions of stable character traits, and virtue was linked to acts that served to protect or enhance fundamental values attached to ontological security and human flourishing. Virtue ethics, in this sense, was the single most important ethical system for each of the participants.

Conclusion   Virtue ethics, construed as the appraisal of acts in contexts of risk, danger or threat to foundational values, emerged as the 'natural' ethical approach for medical practitioners in this case study. Teaching medical ethics to students and graduates alike needs to accommodate the priority attached to virtuous acts.

Introduction

Over the past 30 years, principle-based ethics has come to dominate medical ethics – at least as practices in the 'clinic'. And while virtue ethics has been revived by ethicists such as Anscombe, Campbell, Foot, Macintyre, Nussbaum, Pellegrino, Wright, Zagzebski, Crisp and Kupperman [1–14], its place seems less secure than principlism or consequentialism in the day-to-day discussions of ethical quandaries.

Virtue ethics distinguishes itself from other ethical frameworks by appealing to the 'good' agency of the individual. It suggests that the ethical individual makes moral choices to fit the unique features of each context. It has an established, but insecure, foothold in bioethics [2,7,15,16] and has been

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criticized on many grounds, including its potential relativism, its circular logic, its linkage to motives that are largely undiscoverable and its dependence on the disputed notion of human characteristics that endure across time and contexts [17,18]. In addition, there is the difficulty in defining the virtues themselves [14]. Nevertheless, virtue ethics appeals to medical practitioners (see e.g. [7,16]), who seem to recognize their central importance, given the stated telos of medicine as preserver and restorer of health.

Virtues are commonly characterized in discourse by linguistic labels, by nouns. These labels (such as benevolence, courage, wisdom, compassion) reify and hypostasize complex abstractions. They are also 'place holders' for cognitive, emotional, moral and aesthetic responses to deeds, actions, judgments and texts. In The Analects, Confucius defines perfect virtue as the practice of 'gravity, generosity of soul, sincerity, earnestness and kindness'. Aristotle argued that virtues such as courage, temperance and generosity were to be found in the 'golden mean' between the extremes. The mediaevals, drawing on Greek traditions, defined four cardinal virtues: prudence, courage, temperance and justice. To these were added the religious virtues of faith, hope and charity [19,20]. There is a long list of subsidiary virtues [6]. All of these virtues are linked, either causally or conceptually, to human flourishing [21].

The function or locus of action of virtues has long been the subject of debate. Virtues may cause or facilitate the flourishing of the virtuous person, and they may be construed as facilitating the flourishing of other individuals, groups, communities, nations or even the welfare of all sentient beings. We believe, however, that virtues can best be defined by their function – to protect and promote the many and various culturally relevant practices that express the foundational values attached to survival, security and human flourishing in the context of a community that respects the autonomy and rights of all its members.

Virtues, therefore, are morally important not because they define a series of desirable character traits, but because they provide a moral basis for action [17]. Thus, while identifying specific virtues may remain useful in discourse, we do not need to argue about what name should be given to a virtuous act, whether it is to be called 'courageous', 'prudent', 'charitable' and so on, for a virtuous action is one that fulfils the criterion of intentionally protecting the foundational values.

With this construction of virtues and virtue ethics in mind, we conducted an empirical, qualitative study of the ways in which a group of medical practitioners identified and valued virtues in themselves and colleagues.

Methods

The present study is part of a broader project, a case study of graduates associated with the Sydney Medical School. The 'caseness' of this group [22] is determined first by the association of all the interviewees with medical education within the Sydney Medical School, either as graduates from the programme, or as graduates from other schools now working within the Sydney system as teachers, researchers or administrators; and second by each person's preparedness to discuss their careers and their perceptions of the ways in which values matter in their practices and their educational experiences. Recorded interviews were semi-structured, using a few standard prompts, and people were encouraged to reflect on episodes in their careers that had stayed in their minds because of their moral dimensions. They were also asked to talk about specific issues such as the cost of health care, the availability of health services, the appropriateness of the medical education programme that they had received or were teaching, the place of evidence and research in medical education and practice, and the impact of role models and mentors. Interviews were conducted by a medical practitioner and a psychology graduate, either together or separately. Information sheets were sent

to all interviewees beforehand. Informed consent was routinely obtained for the interview and for the use of anonymized data from transcripts, which were typed by a professional transcriber and edited by the two interviewers. Ethical clearances were obtained from the University of Sydney and from participating hospitals. Interviews were conducted within the University, in hospitals and in doctors' rooms, according to the choices of interviewees.

We interviewed seven women and 12 men. Ages ranged from 28 to 76 years, and years since graduation from two to 52. There were nine different medical specialties represented, including four doctors in general (family) practice. The interview transcripts were thematically coded for virtues, and a process of dialectical empiricism [23] used to categorize the emergent themes into more abstract concepts, using constant comparison [22,24–28] and reformulation of research questions and theories [29]. We reached agreement about themes, codes and categories at regular meetings of the main research group (J. G., L. R., P. M., I. K. and M. L.), with comment and critiques from Dr C.F.C. Jordens and Dr Claire Hooker (see Acknowledgements).

For this part of the study, the research group characterized virtues as decisions or acts that were judged to promote or protect the foundational needs of survival, security and flourishing within the context of Australian medical practice. The selected quotes in Results give typical examples. All quotations are referenced against paragraphs numbered in the transcripts of interviews. Thus, 7.37 refers to the 37th paragraph in the transcript of participant 7's interview.

Results

Early in the study, the research group noted a particular feature of the 'virtue talk' among the interviewees as they responded to prompts about memorable people or incidents. When they spoke of their own virtues or the virtues of others, they tended to place those virtues on a behavioural continuum. For example, they would balance altruistic behaviour against self-regarding behaviour, and rate the importance of each according to the context of the narrated episode. The interviewees resolved the tension between the extremes by a process of self-placement or 'balancing' that resembled an informal use of dialectic [30]. Examples of this are given in the data below. It seemed that each person was seeking a 'golden mean' in moral quandaries, and that the golden mean moved according to context.

We identified three categories in which a continuum is apparent – attitudes to the relative importance of the clinical dyad (the individual case encounter) versus the collective in medical practice, attitudes towards the priorities of others as opposed to protection of the self and opinions about the virtue of conformity to accepted practices versus resistance to them under exceptional circumstances. We identified two meta-virtues – phronesis and prudence – that interviewees called upon or admired in others. They appear to be the sovereign guides through moral quandaries caused by the tensions between the extremes on each continuum. The interviewees' awareness of an absolute standard, plus an awareness of what they admire in others plus an awareness of one's own 'best' self appeared to contribute to both phronesis and prudence.
Dyad–collective continuum

Interviewees commonly situated themselves towards one or other end of the continuum between emphasizing the importance of the dyadic relationship or the importance of the collective in affirming the virtue of protecting or promoting foundational values. Participant 2 recognizes the priority of the dyad:

2.68 I think the medical, um, an encounter between a patient and a clinician is basically an encounter between two human beings, and therefore it's primarily an issue of relationships and

communication. There's the technical stuff which needs to clearly be fed into that, and there may be things that we learn from research which can help clinicians know how to manage the relationship, but I mean essentially we're left with two people talking to each other, and a large part of that is maybe informed by the research, but it essentially is the art of being people, communicating and talking.

In the dialectical spirit, participant 2 later, however, shows how strongly he commits to learning from collective data, and implementing research at community level:

2.74 I think there is an accentuation of an individual patient without adequate regard for what can be learnt from some quantification of the experience of the previous ones to feed into that. And I think the researchers are often to blame, because researchers and journals are not interested in that sort of information. It's local, and it's hard to get published, so often, that's often where information is incorrect.

Participant 1 recognizes the perverse incentives that can tempt clinicians into non-virtuous behaviour, when they fail to focus on their dyadic relationship with patients and turn their attention either to minimizing effort (under a National Health System) or to maximizing income in a fee-for-service environment.

1.60 I've talked to colleagues in the UK where . . . some practitioners will take an approach where they really don't mind if patients can't be seen on one day, because they're getting their pay for the number of people they've got on their books . . . Whereas on the other hand our system can be rorted by some people who churn people through to maximize their income without the quality.

A junior doctor, participant 16, admires a consultant who balances the needs of individual patients, the whole population of emergency department patients and the need to train more junior doctors, even under difficult circumstances:

16.19 The other things I admire in them is the way they deal with emergency medicine, in terms of not just looking at each patient individually, but managing the flow. We're a bit understaffed because of various things, and I think our department has hit a very low point . . . So what I admire is the consultant, rather than leaving a sinking ship (he's) sticking around and not complaining and just getting on with the job, and doing the job well. And also realizing my needs for my training, so the need for me to learn. So if there's procedures that I haven't done, to give me the time to supervise me and actually do the procedure with me, rather than say 'Oh look we've got 20 patients waiting, it's too busy, just ring ICU and get them to do it', which they could easily do. So to kind of balance the needs of the department, the needs of the patient, as well as my training needs.

Another interviewee reflected on her relationship with individual patients:

5.22 I can tell you every one of them who has died, particularly the ones with children. They're all burnt in my memory. . . . the thought of someone being sick or dying and leaving young children I sort of find really . . . those patients stand out a lot. . . .

and on her responsibility to use health care resources to maximize benefit for the whole population of patients who come under her care:

5.24 . . . it's not even just about the budget, it's about the appropriateness of doing everything to everyone. And I make, and most colleagues make, those decisions every single day, or you can call it rationing, and it is rationing, and it happens at all levels in the hospital.

Otherness–selfness continuum

Most interviewees recognized that their role as doctors demanded service to others. They also recognized that attention to self-care was important, because burnout and fatigue can be as dangerous as ignorance or lack of care for others:

4.9 It was just a rotation, and I was getting a bit too connected. . . . And he (my consultant) was actually very sweet to me. He said 'I think you're getting too . . .' He came across me one day just feeling overwhelmed, and he said 'You need two days off . . .' And I went up to my parents' place at the beach, and then I came back, and I was just a bit more considered and thoughtful about boundaries . . .

Some identified situations in which their personal safety was at risk:

18.66 When I was working in western Sydney in paediatrics, I'd see a lot of child protection work in the families I was dealing with . . . and so I found myself expecting the worst, and sort of being careful about my own personal security in a way that I hadn't before. I mean for example, not walking home at night after a train from Central Sydney.

For most, there was also a sense of obligation that accompanied their roles as doctors, and their publicly subsidized education within the Australian system:

5.84 Why do I work in a public hospital? There are lots of reasons, but it's partly enjoyment, the stimulation of having a training environment, with meetings, communication with colleagues. It's definitely a public commitment thing of having a good tax-payer funded education, and feeling that I owe the community use of my skills and training, regardless of their situation.

Participant 10, a staff specialist, recognizes the importance of money as a potential agent of self-interest and threat to objectivity:

10.49 I'm probably not going to cast stones, because if I was in that same situation and I saw a patient and I'd be getting $10 000 in my own pocket for each patient I treat, that's my term school fees. When you're in a situation, I think there's a conflict of interest when there's money. Your decisions are based on money. Whereas I don't get paid a cent, treating one patient or 500, so I tend to think I'll provide impartial advice, which is nice.

Conformity–resistance continuum

Enculturation in any profession encourages members to conform to guidelines and protocols, which in turn provokes some people to resist them [31]. Guidelines and protocols have their strengths and weaknesses. They provide a body of knowledge upon which practitioners can draw, and pre-approval of certain practices; but they cannot be usefully applied in all settings and are unable to cope with nuance or complexity in clinical medicine. Participant 2, for example, protests about the way in which the medical profession, representing conformity, hides behind the formula of 'maintaining standards':

2.89 And we were really angry with the medical profession because they kept on saying 'you know, we have to maintain standards', blah blah blah, but I mean none of them were out there in the places where people needed care. So it was intensely hypocritical, and made me very angry, and still makes me very angry.

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Participant 4 also sees the ways in which entrenched habits and relationships to bureaucracies impede a true implementation of best practices:

4.8 The other thing is I think we want to help these people, and we see sometimes the hospital as, not quite the enemy, but as the group that we have to work somehow around . . . that we have to somehow manipulate so they'll actually provide the services that we think are needed, or the resources, or really understand that this is important. A sense of a few gathered against the vast . . . that are yet to understand the importance of what we are doing.

Instances of conformity were less frequent, and tended to refer to clinical decisions. For example, participant 15, a junior doctor, positions herself in line with the norms of her specialty for treatment decisions:

15.64 So I don't think I give more lines of chemo than other people. All oncologists tend to keep treating, and then reach a stage where they realize it's not working and stop. But it is hard to stop. So I don't think in that regard I over treat, but I think I probably do stop when I think other colleagues would also be stopping. Maybe some would stop a bit earlier, maybe some would keep going, but I don't think I necessarily do more or less than the typical . . .

The meta-virtues
<u>Phronesis</u>

It is not surprising that doctors think highly of phronesis, the meta-virtue of practical wisdom, of practical beneficence [21]. Medicine, like all professions, involves the making of decisions that affect both others and the decision maker. And because medical decisions are so closely linked to the physical and emotional welfare of others, there is an especial poignancy and risk of future regret. Almost all interviewees commend phronesis in others, and seek it for themselves:

4.33 He was the sort of person. . . . he was an amazing diagnostician. He could go up to a patient and listen intently to the history . . . People would get him if they didn't know what was going on, because he could work out what was going on with these patients . . .

Some interviewees could see the development of their own phronesis, and could recognize some of its components. Participant 10 reflects on his own development of a philosophy of practice:

10.63 I'm a quality of life believer, so improve the quantity and quality of life. And empathetic, in an evidence-based way. And I suppose also to be responsible for health resources as well. Be conscious of the whole unit, how it fits in with the whole economy and the universe and those sorts of things. It's a very hard general sort of question, isn't it? But I'm a pretty firm believer in quality of life. You look at the whole package.

<u>Prudence</u>

Prudence is the wisdom involved in avoiding harm, both to patients and to oneself. It is close to non-maleficence in principle-based ethics. It involves balance, empathy, self-awareness and reflection on present and past experience:

4.55 . . . a very complicated patient, and we spent two or three hours working out a plan for fluid management over the weekend, and informing all the staff and having a system there. And this person was just so caring. he was just thinking it through so carefully . . . He was so thorough, and so

careful and worrying about these things . . . So that's an example of an amazing clinician. He was revered for his clinical skills there.

The avoidance of harm often involves the capacity to weigh the evidence and decide not to intervene:

9.20 Because there are circumstances where there is a clear and substantial benefit for a treatment, and I think it's not so difficult to discuss what to do. But I think a lot of the time the evidence is not so overwhelming, or the benefits are small, and there are minuses as well as the pluses, and so the more finely balanced that decision, the greater the extent of the person's kind of philosophy and attitudes and things.

Discussion

The doctors in our study were all asked to reflect on their lives, careers and values. When they did so, they tended to describe patients, colleagues, practices and/or decisions by reference to a version of virtue ethics. This was especially the case when talking about moral quandaries and choices. While some made reference to the principles of autonomy, beneficence, non-maleficence and justice, these were almost always linked to a recognition of contextual prudence or phronesis, and to the virtue of respect for another person's values.

Notably, our interviewees repeatedly sought a balance between two extreme positions or virtues – between altruism and self-concern, between conformity and resistance, and between the dyadic doctor–patient relationship and responsibilities to whole communities. In doing so they recognized that each virtue has merit but that each needs to be tempered and/or interpreted according to the context. They recognized, for example, that evidence-based medicine will effectively generate knowledge about collectives but that this may or may not benefit individuals, and that self-protection may at times be necessary in order to sustain altruism. Virtues are therefore context-determined and dynamic. And they are always deployed to protect or enhance foundational values of survival, security and human flourishing. Where each interviewee placed him- or herself on the scale seems to have been dialectically determined according to the context in which each decision was made [30].

Much discussion of virtue in the ethical literature has been set within an Aristotelian framework [7,21]. The elaboration of cardinal virtues – prudence, justice, courage, temperance, supplemented by the Christian components of faith, hope and charity – has led to a tradition within virtue writing of elaborating and justifying named virtues. Our research leads us to believe that there may be more merit in adopting a functional approach to virtues which is less concerned with naming, and more with defining the role of virtuous acts. We see them as actions, attitudes of mind, intentions that have (or would have) the effect of protecting or promoting the foundational values attached to survival, security and flourishing within the relevant culture.

Virtuous acts then become evident under three sets of circumstances:

- danger, threat or risk1 to foundational needs;
- true dilemmas2 of choice between courses of action that involve balancing benefits or harms to foundational needs, and
- coping with the distortions of judgment that success, including the opportunity to make money, may bring.

Virtuous acts imply placement of the virtuous self within community, culture and context; every virtuous act involves a construction of the self as a related being confronting Levinas's 'Face of the Other'[32]. Within the model of virtues that we suggest, a virtuous act therefore is one that seeks to benefit in some way, be it pragmatic or symbolic, the community within which it is enacted. The act may be truly altruistic, or there may be components of self-interest. Either way, the virtuousness of the act resides in the way it affects others or constitutes a paradigmatic behaviour for them. There are no virtuous actions that do not involve others in some way.

Good outcomes of action may happen by moral luck, which is not necessarily virtuous [33,34]. This suggests that intention is necessary, although not sufficient, to enact virtue [35–37]. It has been claimed that some versions of virtue ethics ignore the evaluation of acts at the expense of the evaluation of agents (see, for reviews, Kupperman [14] and Crisp [13]). We support suggestions that individual acts should be evaluated as virtuous [17,38], and agree with Harman when he writes that 'There is more reason to believe that there are virtuous and vicious acts than to believe that people have virtuous or vicious characters'[17].

But while intention is central to determining whether an action is virtuous, this should be differentiated from motive. A physician may be motivated by a complex of 'ends', including the desire to stay out of trouble, the desire to gain more income, more prestige, more power, the desire to spend more time with family or to have more leisure – all issues raised by interviewees in this study, while at the same time, intending to achieve the best possible outcomes for patients, or for a patient in a particular context, by being an agent of healing or restoration, comfort or care.

And while interviewees did examine the consequences of choices, these consequences were framed in terms of their implications for medical and personal virtues, as when participant 5 examines her own conscience when a desperately ill patient dies:

5.18 I remember one day coming into work and she'd died in the night unexpectedly, and I felt this great sense of relief . . . So yeah, there are lots of patients I remember, but I suppose that's something that made me think ill of myself.

To be a wholly virtuous person, all the time is impossible. To have particular dispositional virtues, such as prudence or justice, is more common – we all know and meet people with strong and consistent senses of justice or prudence or courage that form a part of their identity. It seems, then, that virtuous acts can be done by people who do not have the integrated disposition to virtues to which Aristotle referred, by people who do not necessarily live their lives according to a balance of the cardinal virtues of temperance, prudence, courage and justice, or the religious virtues of faith, hope and charity [17]. Virtuous acts may be individual acts of will, rather than habitual responses to moral challenges.

In this empirical study, interviewees talked about quandaries, career decisions and critical episodes in their lives in terms of virtues and vices. There was no instance of a doctor using moral principles to elucidate the issues arising when confronted by a moral quandary. One explanation for this finding might be the way in which the questions were framed, in asking interviewees to reflect particularly on their own behaviour and the behaviour of others. Nevertheless, it seems that medical practitioners may be more naturally attuned to virtue ethics than they are to a crude form of 'principlism'.

The interpretations of virtuous acts expressed by interviewees took time and reflection to achieve [18]. The process of developing the understandings reported here closely resembles that of radical reflective equilibrium [39], where moral knowledge, experience, discussion and dialectic are all

brought together to consider moral quandaries. The most striking finding from this study was the importance of virtue ethics as a framework for moral reflection and a guide to action [40]. In practice, clinicians appear to engage in a form of constant reflective virtue ethics. The teaching of ethics to medical students and practitioners would almost certainly be enhanced if we were to encourage teachers to recognize and respond to this reality.

Acknowledgements

Footnotes
  1   Danger recognizes dangerous things in the world – smoking is dangerous. Threat is the defined nature of the danger – smoking causes early death, respiratory disease, arterial disease, cancer and dependence. Risk puts measures on the threats –x% of people will develop lung cancer every year after smoking one pack a day for 20 years; y% will develop emphysema.
  2   In ordinary language, a dilemma is a situation in which one has to 'make a choice between two or more conflicting but equally important alternatives'[Bunnin, N. & Yu, J. (eds) (2009) The Blackwell Dictionary of Western Philosophy. Chichester: Wiley-Blackwell. p. 182].

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