AMENDING THE DECLINING PATIENT-PHYSICIAN RELATIONSHIP THROUGH MEDICAL EDUCATION REFORM: A POSTULATE FOR ARISTOTELIAN VIRTUE PEDAGOGY AND ITS AMICABILITY WITH THE U.S. HEALTHCARE SYSTEM

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ABSTRACT

Amending the Declining Patient-Physician Relationship Through Medical Education Reform: A Postulate for Aristotelian Virtue Pedagogy and Its Amicability with the U.S. Healthcare System

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In a complex and technologically sophisticated healthcare system, the utilization of virtues which emphasizes the art of clinical practice is often eclipsed by the technical science of its practice. Consequently, the training of physicians generally focuses on the objective and quantifiable science of clinical practice, which at times cripples the patient-physician relationship. To counter this impact on the patient-physician relationship, medical educators must develop and utilize pedagogical strategies to teach virtues to medical students and residents. In doing so, a character-based virtue theory, proposed by Aristotle, can used to highlight intrinsic mechanisms, namely *phronesis* and *prohairesis*, that lead to virtuous, continent, incontinent, or vicious character-based action. Further, a pedagogy, derived from a holistic understanding of Aristotle's works, focusing on effective means of situational discernment, character-habituation, and reflective systems-II evaluation of action, can serve the physician well in properly addressing the deepest convictions of the patient and fulfilling their expectations and desires for healthcare. In hopes of then maintaining and promoting virtuous action, federal and local medical infrastructure must publish quality-of-care analytics to both physicians and patients, thus imposing market virtues into a system of care through feedback loops. Hence, a call to virtue through education and infrastructural reform is necessary in the U.S. healthcare system, as it amends the patient-physician relationship and promotes the ends of medicine, through practical and humanistic means. For not to follow virtue is to give into vice.

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CHAPTER ONE

The Medical Crisis: The Demise of the Patient-Physician Relationship

In our modern-day healthcare system, physicians face mounting demands on their time. Increasing administrative requirements for health care delivery (e.g., service and authorization requests, utilization review processes) encroach on time spent with patients. The 2005 Commonwealth Fund survey found that 41% of physicians noted a decline in the amount of time spent with patients and 43% noted a decline in the amount of time spent with colleagues between 2002 and 2005.[1] There is an increasing emphasis on value and efficiency in health care delivery as quality time between physician and patient is an increasingly valuable resource. Physicians are required to spend time in face-to-face contact with patients gathering information, developing a relationship, doing administrative work related to visits, and maintaining their knowledge base to practice "cutting-edge" medicine, but the reality of the matter is that this is just not practical within the time and political constraints of the work-day. In addition to the laborious stress that is imposed on healthcare professionals, physicians are faced with the constant backlash and scrutiny of their peers, the hospital administration, and patients.[2] It is evident that our medical society is not only broken, but in an era of crisis and in need of reform.

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[1] Collins KS, Schoen C, Sandman DR. New York, NY: The Commonwealth Fund; 2007. The Commonwealth Fund Survey of Physician Experiences with Managed Care.

[2] Reinke, T. (2007). The push for health care value spurs greater physician scrutiny. *Physician executive*, *33*(4), 42.

At the heart of understanding the contemporary American medical crisis is the patient-physician relationship. According to the 2001 Opinion, published by the American Medical Association (AMA), the patient-physician relationship is the "encounter between patient and a physician, [and] is fundamentally a moral activity that arises from the imperative to care for patients and alleviate suffering...by mutual consent between physician and patient (or surrogate) [and] gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare."[3] At its core, the patient-physician relationship must remain a moral activity that promotes beneficence and well-being. The relationship is grounded in patient welfare and thus must be patient-centered or may fall victim to institutional bias and corruption.[4,5] Unfortunately, this is the case, as fiscal pressure on administrative systems, a culture of efficiency, and fear of medical malpractice have displaced the patient's wellbeing as the purpose of practice, as will be explained below.

The contemporary American medical crisis has risen in-part due to the corruption and fall of the patient-physician relationship. Our medical system has shifted in nature from a patient-centered practice to a economic-centered and efficiency-laden culture As fiscal policy of hospitals and their efforts to cut costs to increase competitiveness or profit

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[3] Opinion 10.015- The Patient-Physician Relationship. *American Medical Association*. 2001.

[4] Oates, J., Weston, W. W., & Jordan, J. (2000). The impact of patient-centered care on outcomes. *Fam Pract*, *49*, 796-804.

[5] Cooper, L. A., Roter, D. L., Johnson, R. L., Ford, D. E., Steinwachs, D. M., & Powe, N. R. (2003). Patient-centered communication, ratings of care, and concordance of patient and physician race. *Annals of internal medicine*,*139*(11), 907-915.

means having doctors be more "productive" by seeing patients faster.[6,7] The first thing dropped as visit length shortens is psychosocial discussion.[8] So far, the average length of visits in the United States does not seem to have dropped significantly, but this is accounted by the inherent inefficiencies in scheduling and a doctors' abilities to finagle time to fit the needs of patients. Yet both patients and doctors feel a heightened sense of time pressure, and patients worry about being on a conveyor belt with a production-line-oriented physician, which has changed the inherent culture of medical practice.

As hospitals and practices attempt to increase a provider's efficiency, these fears will be realized unless acted upon by consumers, professionals, or more visionary organizations. Less time, otherwise, will mean less relating time and damage, which diminishes patient-care and healing through the following slippery slope: less-accurate and incomplete data lead to difficulty in identifying the root issues of illness, through decreased efficiency in tests and treatment choices based on knowledge of the individual patient and thus less trust and healing.[9]

Suddenly, the central focus of medical practice has shifted towards the costs of practice and optimizing efficiency through time-constraints. It is no longer the patient,

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[6] Brown, M. M., Brown, G. C., Sharma, S., & Landy, J. (2003). Health care economic analyses and value-based medicine. *Survey of ophthalmology*,*48*(2), 204-223.

[7] Garber, A. M., & Phelps, C. E. (1997). Economic foundations of cost-effectiveness analysis. *Journal of health economics*, *16*(1), 1-31.

[8] Roland MO, Bartholomew J, Courtenay MJF, Morris RW, Morrell DC. The "five minute" consultation: effective time constraint on verbal communication. BMJ. 1986; 292:874–6.

[9] Tamblyn R, Berkson L, Dauphinee W, et al. Unnecessary prescribing of NSAIDs and the management of NSAID-related gastropathy in medical practice. Ann Intern Med. 1997;127:429–38.

who receives care, but rather the physical being that requires intervention. This new interventionalist culture, as a subset of the economic efficiency culture, mandates quick solutions that are inadequate to the fundamental illness at hand. Rather, it qualifies the illness through standardized definitions, which are often times broad and quite similar, and looks to treat the illness with the best evidence, usually from randomized-control trials, available at the time.[10,11] In doing so, the patient is dehumanized and reduced to a case number that can be efficiently "resolved," though typically not correctly "resolved." In doing so, the patient-physician relationship must be redefined as a patient-consumer relationship and all hopes of humanism in practice are lost.

Next, we must address the series of organizational or system factors also affect the doctor–patient relationship. The accessibility of personnel, both administrative and clinical, and their courtesy level, provide a sense that patients are important and respected, as do reasonable waiting times and attention to personal comfort.[12] The availability of covering nurses and doctors contributes to a sense of security. Reminders and user-friendly educational materials create an atmosphere of caring and concern. The healthcare administration and adjacent medical organizations can promote a patient-centered culture, or one that is profit- or physician-centered, with consequences for

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[10] Starr, P. (1982). *The social transformation of American medicine*. Basic Books.

[11] Tarricone, R. (2006). Cost-of-illness analysis: what room in health economics?. *Health policy*, *77*(1), 51-63.

[12] Detmar, S. B., Muller, M. J., Schornagel, J. H., Wever, L. D., & Aaronson, N. K. (2002). Health-related quality-of-life assessments and patient-physician communication: a randomized controlled trial. *Jama*, *288*(23), 3027-3034.

individual doctor–patient relationships.[13] They promote continuity in clinical relationships, which in turn affect the strength of those relationships. For instance, the former American market-based system with health insurance was linked to employers' whims, with competitive provider networks and frequent mergers and acquisitions that prevented long-term relationships. A health plan that includes the spectrum of outpatient and inpatient, and acute and chronic services has an opportunity to promote continuity across care settings.[10]

Thus, it is apparent that the medical community is suffering from a declining patient-consumer culture, where the political and economic demands override the service and humanistic demands of the patient, but it is also important to note that physicians, themselves, possess another internal stress of medical malpractice and professional scrutiny. As the number of malpractice suits against physicians escalates, the fear of being sued increases comparably, influencing medical decision making and often resulting in an approach known as defensive medicine.[14] Defensive medicine is a practice of medicine centering, as its primary aim, around self-protection from liability in the event of a tragic outcome, rather than affording primacy to the patient's well-being; often it is portrayed as a mechanism to anticipate and forestall hindsight-based second-guessing of clinical decisions like whether or not to order a particular diagnostic test.[15] Defensive

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[13] Gerteis M, Roberts MJ. In: Through the Patient's Eyes. Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL, editors. San Francisco, Calif: Jossey-Bass Publishers; 1993. Culture, leadership and service in the patient-centered hospital.

[14] Weinberger, S. E., Lawrence III, H. C., Henley, D. E., Alden, E. R., & Hoyt, D. B. (2012). Legislative interference with the patient–physician relationship.*New England Journal of Medicine*, *367*(16), 1557-1559.

[15] Summerton, N. (1995). Positive and negative factors in defensive medicine: a questionnaire study of general practitioners. *BMJ*, *310*(6971), 27-29.

medicine may alter the individual clinician's practice or the practice adopted by an entire institution.

A defensive stance undermines one of medicine's basic tasks: providing the best possible health care. I argue that a partial explanation of this failure involves the adverse effects of defensive practice on the therapeutic relationship between physician and patient. The defensive clinician must become less empathic and more distant, in his or her stance toward the patient, and rely strictly on empirical data and documentation. Clinicians who practice defensively tend to seek data of an objective nature in preference to the sometimes more meaningful subjective data such as psychosocial information.[16,17] Simply stated, a courageous clinician may seek to know the patient better as a person, whereas a fearful clinician is more likely to focus and act upon test results. Hence, there is an inherent fear of malpractice or unjustified procedures, when it comes to the treatment of patients, such that the physician feels pressured to practice in a conservative, and thus less engaged manner that further perpetuates the decline of the patient-physician relationship.[18]

Thus, there is a major need for reform in amending the patient-physician relationship and recentralizing the patient's wellbeing as the chief goal of medicine, but

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[16] Kessler, D. P., & McClellan, M. (1996). *Do doctors practice defensive medicine?* (No. w5466). National Bureau of Economic Research.

[17] Stimson, C. J. (2016). Hospital Risk Management and the US Legal System: An Introduction to US Medical Malpractice Tort Law. In *Risk Management in Medicine* (pp. 69-76). Springer Berlin Heidelberg.

[18] Hauser MJ, Commons ML, Bursztajn HJ, Gutheil TG. "Fear of Malpractice Liability and its Role in Clinical Decision Making" In Gutheil TG, Bursztajn HJ, Brodsky A, Alexander, V. Decision Making in Psychiatry and the Law. Baltimore: Williams & Wilkins, 1991.

the means by which this reform should take place is in question. Political and fiscal reform has begun to take part through policy creation and reform, in hopes of subsidizing medical costs and establishing stricter standards of care, but the timeframe of governmental intervention, from policy creation to full implementation and regulation, could span a period of years and is typically dampened by the bipartisan scrutiny and attacks.[19,20,21,22] Hospitals and medical organizations are attempting provide reform through more defined practice protocols and incentive programs for patient satisfaction, but these programs are not standard across the entire nation's medical system and tend to be economically-driven, rather than patient-centered.[23] Evidently, a top-down approach, institution to practitioner, of reform will not provide a universal solution in ample time to save the medical system.[24]

Reform must take place through a bottom-up fashion, where engrained in the foundation of practice are humanistic means of amplifying the patient-physician

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[19] Kreindler, S. A. (2015). The politics of patient-centred care. *Health Expectations*, *18*(5), 1139-1150.

[20] Chen, A., & Lakdawalla, D. (2015, November). Saving Lives or Saving Money? Understanding the Dual Nature of Physician Preferences. In *2015 Fall Conference: The Golden Age of Evidence-Based Policy*. Appam.

[21] Poterba, J. M. (1993). *State Responses to Fiscal Crisis: The Effects of Budgetary Institutionsand Politics* (No. w4375). National Bureau of Economic Research.

[22] Grbic, J. (2015). Medical cannabis in the United States: Policy, politics and science.

[23] Huntington, W. V., Covington, L. A., Center, P. P., Covington, L. A., & Manchikanti, L. (2011). Patient Protection and Affordable Care Act of 2010: reforming the health care reform for the new decade. *Pain Physician*, *14*(1), E35-E67.

[24] Fullan, M. (1994). Coordinating top-down and bottom-up strategies for educational reform. *Systemic reform: Perspectives on personalizing education*, 7-23.

relationship.[24] I argue that reform must take place at the level of medical education, as educators will supplement the technical aspects of medical practice, both medically and structurally, with humanistic practices of the art. Medical schools have launched a reform initiative to tackle the education of the practice of medicine. I concede that medical education reform is not the final solution to tackling the entirety of the American medical crisis, but it is a solution that addresses a core issue in the American medical crisis, the declining patient-physician relationship, in a quick and practical timeline that is grounded in the maintenance of the patient as the center focus of medicine.

New goals of a revolutionary sort are taking shape in medical schools. Concerned over the narrow technical training of medical students and their lack of preparation to face the complex challenges of contemporary medicine, medical schools have, in an astonishing burst of reform within the past decade or so, developed new curricular strategies to balance the traditional emphasis on technical sciences with humanistic clinical practice.[25] These curricular efforts emphasize practical approaches to such topics as medical ethics, patient narratives, spirituality, and death and dying, in order to improve a student's understanding of the ethical, humanistic, and practical dimensions of the physician–patient relationship.[26,27]

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[25] Medical School Objectives Writing Group. Learning Objectives for Medical Student Education—Guidelines for Medical Schools: Report I of the Medical School Objectives Project. Acad Med. 2009; 74:13-8.

[26] Steinbrook, R. (2014). Interstate medical licensure: major reform of licensing to encourage medical practice in multiple states. *JAMA*, *312*(7), 695-696.

[27] Scally, C. P., Gauger, P. G., & Dimick, J. B. (2015). The Institute of Medicine Report on Graduate Medical Education Funding: Implications for Surgical Training. *JAMA surgery*, *150*(6), 501-502.

To date, medical school courses and curriculum categorize the art of clinical practice as a loosely organized and undefined medical discipline. There is a lack of structure and definition in this discipline, as exemplified by such terms as "medical humanism," "professionalism in medicine," "humanities and medicine," and "medical phenomenology," often being used interchangeably. What to call this emerging discipline is a pressing problem, as this is a growing field in medical education and the terms by which this practice should operate are unclear and still lack standardization.[28] Moreover, what are its goals and unifying principles, particularly as it attempts to guide medical students to become good doctors? At root, I argue, medical educators must teach the virtues relevant to clinical practice to medical students and residents, and challenge them in humanistic scenarios and conversations, where the question of virtue and phenomenology must be reconciled with the evidence-based practice of person-centered medicine. This argument will be further explored in the following chapters.

[28] Bloom, B. S. (2005). Effects of continuing medical education on improving physician clinical care and patient health: a review of systematic reviews. *International journal of technology assessment in health care*, *21*(03), 380-385.

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CHAPTER TWO

Creating the "Virtuous" Physician: Defining and Standardizing Virtue through the Aristotelian Framework

Patients certainly desire the skill of technical competence in physicians. Grounded in the perceived ideal of the 'good' doctor, this skill exemplifies an important goal of the medical professional. Most medical educators would include among those traits the 'civil' virtues, i.e. virtues that transcend most cultural value differences. These virtues include such characteristics as respect, compassion, and honesty, and they are fundamental to any morality that professional medical caregivers are expected to embrace. These fundamental virtues inaugurate the transformation of the 'good' doctor to a status of a 'virtuous' one.[1]

An important question for integrating virtue into the medical curriculum and clinical practice is how to conceptualize virtue. Unfortunately, virtue means many different things, especially since the term originates from religious and moral traditions. Virtue is commonly viewed as morally presumptuous, as it may connote the imposition of some ultimate standard. For example, it is defined as 'conformity to a standard of right'.[2] Alternatively, scholars and practitioners have turned to such alternatives as existential philosophy, Judeo-Christian theology, Kantian moral imperatives, psy-

[1] Pellegrino ED, Thomasma DC. For the Patient's Good. New York: Oxford University Press, 1988.

[2] Sykes, J. Virtue. In The Concise Oxford dictionary of current English: Based on the Oxford English dictionary and its supplements. 6th ed. Oxford, Eng.: Clarendon Press, 1976.

choanalytic theory, or literary models to assist in articulating the nature of virtue robust enough to guide teaching of medicine and its practice.[3,4,5]

Which of the above options for defining virtue should be used to teach contemporary medical students? This question reflects the complexity of proposing a virtue-based approach to medical education within a postmodern era shaped by the failed attempt of the Enlightenment era to ground morality on a universally rational basis.[25] Some scholars claim we are left without any objective means to identify between what is right and wrong.[6] In addition, the rise of a powerful individualism in Western society, especially in the United States during the past two centuries, has abandoned individuals to their own resources for moral authority. Human freedom implies that individuals have the right to exercise their own discretion about how to act and how to live.[7] Clearly, no single moral principle or religious commandment or dogma can provide a substantive basis for right action in such an environment. In a setting of individualism and in a profession that prizes individualism, medical educators are often expected simply to assume that students can improvise their own professional and moral identity, according

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[3] MacIntyre A. After Virtue. 2nd ed. Notre Dame, IN: University of Notre Dame Press, 1984. Pellegrino ED, Thomasma DC. The Virtues in Medical Practice. New York: Oxford University Press, 1993.

[4] Pellegrino, E. D., & Thomasma, D. C. (1996). *The Christian virtues in medical practice*. Georgetown University Press.

[5] Marcum, J. A. (2012). *The virtuous physician: the role of virtue in medicine*(Vol. 114). Springer Science & Business Media.

[6] Rom R. Contingency, Irony and Solidarity. Cambridge, U.K.: Cambridge University Press, 1989.

[7] Helwig, C. C. (2006). The development of personal autonomy throughout cultures. *Cognitive Development*, *21*(4), 458-473.

to their own personal standards (when historical and modern evidence has proven otherwise).[8]

Philosophical ethics in the Anglo-American tradition for most of the twentieth century focused on "meta-ethics," or the analysis and clarification of ethical terms, and attempted to provide a theoretical justification of right action. The rise of bioethics during the past several decades has returned philosophy to the everyday world by assisting practitioners to grapple with problems that require concrete resolution.[9] Bioethics has provided a bridge between philosophical forms of moral assessment and the messy domain of human actions, particularly in the realms of human illness and clinical decision making. It has had an impact in medical education by teaching students and practitioners to think critically about value dilemmas in clinical practice.[10] However, with respect to such ongoing fundamental bioethical conflicts as abortion, physician-assisted suicide, and human cloning, it is clear that philosophical ethics within a pluralistic setting does not have the moral force to achieve consensus on a single normative standard that would generate definitive resolutions—especially for individual patients. Although modern society's pluralistic nature seems to oppose the movement for a consensus virtue standard, the need for such a standard appears to be the only social means for progress to a greater social good in medicine.[10,11]

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[8] Shafer, H. The American Medical Profession, 1783 to 1850. New York: Columbia University Press.

[9] MacIntyre, A. (2003). *A Short History of Ethics: a history of moral philosophy from the Homeric age to the 20th century*. Routledge.

[10] Shryock, R. The Development of Modern Medicine. New York: Knopf, 1947.

[11] Pellegrino, E. D. (1995). Toward a virtue-based normative ethics for the health professions. *Kennedy Institute of Ethics Journal*, *5*(3), 253-277.

As medical educators continue to advance and develop their pedagogy, there is an urgent need for a common language with which to describe the goals of a coherent, collectively understandable moral framework in clinical practice. Generally, patients want physicians to be individuals and to manifest their individual humanity in unique ways, using their own internal resources to apply their medical knowledge through a virtuous practice.[12] Yet, there are professional and ethical boundaries within which individuality must manifest itself in medicine. The act of entering the medical profession should require physicians to embrace and manifest certain characteristics indicative of the 'virtuous' physician.[13] Thus, I submit to the reader a model of virtue adequate for contemporary medicine through the Aristotelian framework.

The original Aristotelian concept of virtue can provide guidance for medical educators.[14] Aristotle taught that virtue in general is that which enables people to become what they most essentially are; i.e. virtue is the mark of excellence in function. He believed that a person becomes virtuous by learning the right habits through education. Thus, virtue does not entail mindlessly and mechanically following rules or repeating practiced drills. A life of virtue stems from a well-developed character, which, in turn, results from having performed virtuous acts in such a way that they become habits. Performing virtuous acts also requires self-awareness and the free will to choose to act in

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[12] Ende, J., Kazis, L., Ash, A., & Moskowitz, M. A. (1989). Measuring patients' desire for autonomy. *Journal of general internal medicine*, *4*(1), 23-30.

[13] Noddings, N. (2002). *Educating moral people: A caring alternative to character education*. Teachers College Press, PO Box 20, Williston, VT

[14] Aristotle. Nicomachean Ethics. Ostwald M, translator. New York: Macmillan, 1962.

a virtuous manner.[15] Hence, virtue becomes ingrained as a natural way of living and flows from one's character because of developing the habits based upon observing virtuous role models. A person of virtue reaches a level of internal harmony or integration between individuality and the community, between freedom and adherence to ideals, between cognition and emotion.[6]

Aristotle's doctrine of the mean clarifies the meaning of virtues. To Aristotle, virtue is a proper balance between the extremes of deficiency and excess—or vices. For example, courage is the mean between cowardliness and recklessness. By concentrating on Aristotelian virtues, medical educators can encourage medical students and residents to manifest characteristics that can be defined within a general framework, so that they can develop their own individual styles.[16] The 'virtuous' physician embodies these characteristics and displays them consistently in caring for patients.

Specific kinds of human activities elicit specific virtues, which Aristotle described as 'states of character'. The person who excels in an activity often demonstrates the virtues or states of character required for these activities. Role models who exemplify and embody the ideal performance for such activities serve as a standard by which to judge performance and a template on which to model one's own actions.[17] Because human beings simultaneously perform individual and social acts, virtues embodied by individuals reflect both personal and transpersonal or interpersonal ends associated with

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[15] Ryan, K., & Bohlin, K. E. (1999). *Building Character in Schools: Practical Ways To Bring Moral Instruction to Life*. Jossey-Bass Inc., Publishers, 350 Sansome St., San Francisco, CA 94104.

[16] Kamtekar, R. (2004). Situationism and Virtue Ethics on the Content of Our Character*. *Ethics*, *114*(3), 458-491.

[17] *Nichomachean Ethics. 1108b10-1109a17*

those acts.[18] For example, because the goal of medicine is to relieve suffering by caring for the sick, the virtuous acts of individual physicians promote both their own professional excellence and the capacity of the medical institution to accomplish its. Thus, virtues allow individuals to fulfill both their personal function and the ultimate function of the profession's activity in which they participate.

The purpose of this thesis is to propose that medical educators use Aristotle's framework of virtue as a touchstone for accomplishing their goals in training medical students. To that end, eduators need to rethink and debate with renewed interest on what it means to be a 'virtuous' physician. This includes several non-negotiable expectations for students, who have committed themselves to the profession of medicine. For example, should the educator tolerate medical students who deride the value of learning how to engage in empathetic listening, to listen to and to appreciate patient narratives, and to develop skills in ethical discernment? And, what about students who believe that such skills are not essential in becoming a good and effective doctor?

The above questions have yet to be answered satisfactorily, but I argue that Aristotelian virtues provide a resolution to the creation of a standard of virtuous practice. Specifically, for Aristotle, *phronesis* or practical wisdom serves as the chief virtue to operationalize other virtues.[19] Medical educators then must develop a pedagogical strategy to teach practical wisdom first, such that the technical education and the clinical experience are matched by a virtuous means of insight to the clinical encounter. In doing

[18] -----. 1109a20-b25

[19] -----. 1142a31-1145a10

so, the student's immediate reaction is to recognize how virtue can help to provide the best clinical decision and action.

To be viable for medical training, a virtue must serve as a unifying principle to articulate the goals of medical education. Such a concept of virtue in contemporary medical education and practice must accommodate a pluralistic society in which reasonable people often disagree about how fundamental values apply to certain situations.[20] Therefore, we must admit that in today's health care setting, 'virtuous' physicians do not necessary have definitive answers to fundamental moral quandaries. What they do need to have are non-negotiable procedural social values such as respect for equality, freedom, and human rights.[21] In the contemporary health care system, these procedural values reflect the capacity and courage to function professionally in an environment in which moral ambiguity is pervasive, to tolerate moral differences and uncertainties in order to develop thoughtful individual moral agents, and to respect and understand various cultural traditions.[22] These values, in turn, serve to ground the Aristotelian virtues of respect for patient autonomy, beneficence, non-maleficence, compassion, and honesty, which are associated with the 'virtuous' physician.[33]

Finally, these virtues or universally desired characteristics cannot be derived from a clear set of definitive, specific moral rules that are applicable for every occasion. They are meant instead to guide physicians towards respectful and professional interactions

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[20] Veatch, R. M. (1996). Modern vs. contemporary medicine: the patient-provider relation in the twenty-first century. *Kennedy Institute of Ethics Journal*, *6*(4), 366-370.

[21] Freeman, J. W., & Wilson, A. L. (1994). Virtue and longitudinal ethics education in medical school. *South Dakota journal of medicine*, *47*(12), 427-430.

[22] Shelton, W. (1999). Can virtue be taught?. *Academic Medicine*, *74*(6), 671-4.

with patients. These virtues are at the root of efforts to promote humanism and professionalism within clinical practice. This means that teaching particular skills in such domains as patient assessments, accurate interpretation of illness narratives, and the care of the dying, medical educators should be able to instill virtue by role modeling the underlying virtues that allow for humanistic behavioral skills and their capacities to be developed and performed as a person of virtue would perform them.[23]

In conclusion, the lack of standardization in virtue does not preclude teaching virtue, but rather places into question the effectiveness of the methodology, leading modern medical educators to question, 'Can virtue be taught in the modern medical education?' Any approach attempting to prepare medical students to function as fully competent physicians, trained to care for the patient's needs, must include virtues. Choosing the most effective and respectful means of achieving such a goal is contemporary medicine's urgent challenge. For not to reach virtues, is to leave the door open for vices.

[23] Toon, P. D. (1993). After bioethics and towards virtue?. *Journal of medical ethics*, *19*(1), 17-18.

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CHAPTER THREE

A Pedagogy on Virtue Education in Medicine Derived from Aristotle

Modern medical education is undergoing radical change, particularly in terms of re-introducing the art of medicine. As noted above, the American Association of Medical Colleges has already taken an admirable leadership role towards this end in its Medical School Objectives Project.[25] The Aristotelian virtue framework provides modern medical educators with a means by which they can incorporate virtue into the teaching curriculum. But, there is need to think critically about which of the Aristotelian virtues can facilitate this goal, given the diverse range of concrete clinical practices. Importantly, these virtues should be formulated and agreed upon in response to the challenges of medical practice. Specific curricular strategies must then be developed with testable outcome measures to accomplish these strategies. Above all, medical students should be provided with the challenge and given the necessary support to do their best to operationalize and realize the standard of excellence that virtue requires.

It is unlikely that a single course within a formal medical curriculum is adequate for the task of teaching virtue, since both the formal and informal curricula contribute to the development of the student's values, character, and virtues. The goal of teaching virtue then must be understood as an institutional mission, located within the profession of medicine, based on formal and strategic curricular innovations and supportive clinical role modeling. This implies that there must be community consensus, which explicitly defines its professional mission, sets clear and visible expectations for those who enter the profession, and is committed to teaching the standard through consistent modeling.

Toward this end, the community would benefit from utilizing Aristotelian virtues to achieve these curricular goals. The educator's prime responsibility is to embody and exemplify the habits of virtue in action. This model calls upon both a relativist and situational approach to virtuous action in medical education.

Modern cultural and religious fragmentation is now common throughout the modern world and prevents any single, foundational standard of virtue to be established, thus calling for an adaptive means of defining and then teaching virtues.[1,2] For Aristotle, practical reason (*phronesis*) molds behavior by requiring agents to act in a way that is appropriate to a given situation, as determined by rational deliberation (*prohairesis*).[3] If a virtue is a 'mean', especially between two extremes or vices, then it is always relative to the individual and to the conditions under which a particular action is performed; and it therefore certainly requires careful deliberation.[4] A part of the process of operationalizing the virtues in individuals, especially in students, is equipping them with the ability to engage in deliberation about the relevance of the virtues to the peculiar and perhaps unique conditions of clinical encounters, especially their moral demands. The morally appropriate and thus virtuous action is always the one that takes into account the specifics of a given situation.[5]

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[1] Gross, M. L. (1999). Ethics education and physician morality. *Social Science & Medicine*, *49*(3), 329-342.

[2] Prinz, J. (2009). The normativity challenge: Cultural psychology provides the real threat to virtue ethics. *The Journal of Ethics*, *13*(2-3), 117-144.

[3] *Nichomachean Ethics.*1142b5-1143a10

[4] *Nichomachean Ethics.* 1109a20-b25

[5] Wilson, M. K. (2008). Situational and Individual Difference Variables in Medical Ethical Judgments.

Moral education, through increased moral reasoning skills, is useful for improving the professional responsibility of general performance for members of medical professional groups. For example, Donnie Self found that the clinical performance of medical students was positively correlated with proficiency in moral reasoning.[6,7] He also found that moral reasoning could be improved through classes in medical ethics and small-group discussions of moral issues, based on actual clinical scenarios.[8]

Moreover, clinical role modeling can be utilized as a means of acquiring *phronesis* or the practical reasoning skills to act virtuously in a given situation. The issue still at hand, however, is a matter of defining a "standard" of virtue that guides how the clinical role model and student might respond to particular clinical scenarios. Modern critics point out that in a society of cultural and moral fragmentation, it is not practical to expect every clinical role model to share a common moral framework to ground a virtuous standard. Each role model would most likely teach under a particular moral framework and respond differently to each situation. Critics claim that care must be exercised to ensure that Aristotelian role modeling will not succumb to an education in virtue relative to the role modeler and consequently fragmented, rather than standardized.[9,10,11] However, these critics focus on the ends of achieving virtuous

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[6] Self, D. J., Wolinsky, F. D., & Baldwin Jr, D. C. (1989). The effect of teaching medical ethics on medical students' moral reasoning. *Academic medicine*, *64*(12), 755-9.

[7] Self, D. J., & Wolinsky, F. D. (1992). Evaluation of teaching medical ethics by an assessment of moral reasoning. *Medical education*, *26*(3), 178-184.

[8] Self, D.J. Effects of Teaching Moral Reasoning: An Empirical Review and Its Implications. Annals of Behavioral Science and Medical Education. Pennsylvania: Wolters Kluwer Press.

[9] Kamtekar, R. (2004). Situationism and Virtue Ethics on the Content of Our Character. *Ethics*, *114*(3), 458-491.

practice, rather than accepting the means, as Aristotle warns in Book II of *Nichomachean Ethics*. He states that:

> "we deliberate not about ends, but about the things that promote the ends. For neither the doctor deliberates if he should heal, nor the orator if he should persuade, nor the politician if he should produce good order, nor does anyone else deliberate about his end. But positing the end, they consider how and through what means it will be achieved. And if it seems that it can be achieved by several means, they consider further by which one it is *most easily* [*raista*] and *best* [*kallista*] realized. And if it is achieved by only one means, they consider *how* it is achieved by that means, and how *that* means is itself achieved, until they come to the first cause which is last to be discovered … And if they come upon an impossibility, they give up the search."[12]

The matter at hand is how to overcome the situationalism of medical practice and create a meta-approach to applying and understanding virtues, as they apply to medical practice. In doing so, we will be require to understand how to discern the particulars and teach others how to act in accordance to a meta-understanding of virtue.

An understanding of virtue is predicated by 4 key principles: (*Principle I*) The virtuous individual must have knowledge of virtue in a situation (*boulesis*); (*Principle II*) The virtuous individual must possess the proper desire for the promotion of the Good through virtue (*epithumia*); (*Principle III*) The virtuous individual must choose an action according to rational deliberation (*prohairesis*); and (*Principle IV*) The virtuous individual must always question if they are actually promoting the Good through their actions (*praxis*). A failure of any set of these principles will lead to one of Aristotle's spectral forms of character, as given in the figure following.[13]

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[10] Sabini, J., & Silver, M.. (2005). Lack of Character? Situationism Critiqued. *Ethics*, *115*(3), 535–562. http://doi.org/10.1086/428459

[11] Upton, C. L. (2009). Virtue ethics and moral psychology: the situationism debate. *The Journal of ethics*, *13*(2), 103-115.

[12] ref. *Nicomachean Ethics*, 1112b11-13

[13] Sherman, N. (1989). The fabric of character: Aristotle's theory of virtue.

Character Trait	Principle I		Principle II		Principle III		Principle IV
Virtue (*Arête*)	Yes		Yes		Yes		Yes
Continence (*Enkratic*)	Yes		**No**		Yes		Yes
Incontinence (*Akrasia*)	Yes		**No**		**No**		**No**
Vice (*kakos*)	(i) No	(ii)Yes	(i) No	(ii)Yes	(i) No	(ii)Yes	**No**

Figure I: Aristotle's Spectrum of Character

Thus, this chapter submits the following model for teaching the moral character of virtue in medical education. First, the clinical educator must teach medical students how to discern the particulars, both technical and non-technical, in each clinical case. This requires loaded dialogue and the formation of an intimate understanding of the patient's desires and motivations. Second, the clinical educator must teach the medical students how to process the information and understand the virtuous manner of action, defined by the four principles of virtue. This is done by the moral habituation of the character of virtue and a guidance of our natural appetitive dispositions that make up our immediate personality-based response. Finally, the clinical educator must teach the medical student how to apply the virtuous action without straying from the virtuous path. This is often the easiest step, as the student is grounded in virtuous action from the two former steps; however, the most important part of this process is a brief personal reflection on the students' actions in respect to virtue, quality of care, and patient satisfaction.

Step 1: Discerning the Technical and Non-Technical Aspects of the Situation

Every individual discerns a situation differently. We have different motives, desires, and appetitive virtues that must be tamed by *phronesis*. Thus, to teach virtue, the medical educator must teach rational perception (*boulesis*) that is grounded by ethical

consideration from experience and habituation.[14,15] In this way, certain facts are described deontologically and become occasions for evaluative beliefs. Such beliefs about one's situation in turn yield reasons for action, which fall within the motivational structure of specific virtues.[16] They become specific intentions to act upon rational deliberation (*prohairesís*) concerning how and in what way one should warrant a response.[17,18] In doing so, the student maintains a grounding in *boulesis*, or the rational desire to do good as an end goal, and develop the resilience to overcome the aforementioned social factors causing the decline in the patient-physician relationship.

This process, however, requires a choice of virtue and a desire to continually pursue it, as given by *Principle I* and *Principle II*, followed by an active role in self-restrain to reactionary actions.[19] In an immediate situation, all physicians are guided by an appetitive response. The medical educator must select and teach the individuals who desire virtuous action to mentally displace themselves into a contemplative and rational mindset. The student must "step back" and allow for *phronesis* and *prohairesis* to take part in rationalizing appetitive reactions into virtuous responses.[20,21] The selection

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[14] ref. *De Anima*, 432a30

[15] ref. *Nicomachean Ethics*,1102b12–1103a4

[16] ref. *Nicomachean Ethics*, 1104b3, 1174b14–1175a2 ff.

[17] ref. *Eudemian Ethics,* 1220b6–8; 1220a5–13 ff.

[18] ref. *Nicomachean Ethics*,1102b31–1103a3 ff.

[19] ref. *De Motu Animalium,* 1104b3

[20] ref. *Nicomachean Ethics*,1111b27–30, 1113b3–5 ff.

[21] ref. *Eudemian Ethics*, 1226b16

process comes prior to the educational process and thus will not be discussed further; however, the pedagogical structure will be detail in this chapter below.

Medical educators must begin the process by asking how the perceptions constitutive of emotions and subsequent moral responses become refined through the discernment of situational particulars.[22] The educator, in all academic settings, is in the inherent position of persuading through the implicit power of the educational infrastructure.[23] The educator makes prescriptions to the students and the students listen out of a complex set of desires. These desires range from respect towards the educator, to the desire to imitate what is seen as the Good, to a fear of punishment, but mostly hopefully for healthcare promotion through individualistic actions and interventions guided by virtue (*epithumia*). The educator aims not simply to affect specific actions or desires, but rather, tries to bring the student to see the particular circumstances that here and now make certain emotions appropriate.[24] The educator helps the student to construe the clinical case in a way that promotes the *arête* of practice.[25] This will involve persuading the medical student that the situation at hand is to be construed in a virtuous manner, rather than in a way that the medical student takes to be a deliberate assault on his moral choices and character.

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[22] ref. *Nicomachean Ethics*,1109b15–23, 1126b4 ff.

[23] ref. *Rhetoric*, 1374b13–16

[24] ref. *Rhetoric*, 1374b19–27

[25] ref. *Nicomachean Ethics,* 1117a20–22

Step 2: The Cultivation of Moral Character Following Situational Discernment

The clinical educator must teach the student how to displace his emotional response from warranting an immediate appetitive action and allow the students' rational capacities to guide a response through an understanding of the discerned situation and a response guided through a knowledge of the virtuous response.[26] This process will require some form of moral habituation of character through phronetic thinking to guide the response.

Metaphorically, Aristotle states that the student "borrows the eyes of wisdom", and "listens to the words of elders and of the more experienced" in a manner that actively engages his own critical capacities and thus engrains virtue in the habituation of moral character.[27] Accordingly, Aristotle would probably object to the practice of the educator who says, "Do this, don't do that" without further descriptions or explanations, as it lacks the critical reasoning skills needed to sincerely understand the motivations behind one's actions. The student must ask "why," and some description and explanation, whether rational or empirical, must be provided as a means of facilitation proper virtuous rationalization of situational discernment.[28,29] A dialogue about what the student sees and feels and how the student should see and feel provides an actual description, which articulates a way of perceiving the situation and which puts into play the relevant

[26] ref. *De Anima,* 433a18–20, 433b12 ff.

[27] ref. *Nicomachean Ethics,* 1144b10–12, 1143b11–13 ff.

[28] ref. *Politics,* 1143b11–13

[29] ref. *Nicomachean Ethics*,1134b24–5, 1094b11–27

concepts, considerations and emotions needed to guide a virtuous response.[30] It seems to be an essential part of how we train sensitive discernment of the particulars.

Within this, Aristotle can say that there are many proscriptions that the student cannot understand until later and many partial explanations that will have to suffice until then.[31] The point is that emotions that guide moral character cannot be shaped without some simultaneous cultivation of discriminatory abilities. This is included as a part of habituation of character, a proper discernment of the particulars, and in part a forthcoming to the right pleasures and pains guided by rational deliberation towards a virtuous response.[32,33]

As a warning, it is important to note that the emphasis on the internal process must be central to education in a way that it remains at best peripheral to rhetoric.[34] Though the educator exhorts the virtuous action, the goal is not to manipulate beliefs and emotions and influence a specific outcome, but rather to prepare the student for eventually arriving at competent judgments and reactions on his own.[35,36] Any method

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[30] ref. *Politics,* 1253a12

[31] ref. *Nicomachean Ethics*, 1105a25-1105b5

[32] ref. *Nicomachean Ethics,* 1111a25–6, 1111b8–9, 1144b8, 1152b19–20, 1153a28–31, 1176b28–30 ff.

[33] ref. *Eudamian Ethics,*1224a26–30, 1228b19–22, 1236a2–7, 1238a32–34, 1240b31–34 ff.

[34] ref. *Politics*, 1260a34, 1260b3–8 ff.

[35] ref. *Rhetoric*, 1369b6-1370a6, 1374b4–10 ff.

[36] ref. *Nicomachean Ethics*, 1094b11–27, 1134b24–5, 1135b16–1136a9 ff.

which secures rational obedience must at the same time encourage the student's own moral development.

Step 3: Reflection on Virtuous Action

The final and most misunderstood step in virtue education is a reflection on ones actions in respect to virtue. Modern medical education provides adequate speculation of virtuous action through discussion of response in clinical situations; however, these speculations lack the pressures exhorted in actual clinical practice. A speculation provides an idealized personal standard that one theorizes for oneself.[37] But, what is being called for is an immediate and delayed return to internal processes to assess the fulfillment and quality of virtuous action.

Upon immediate response with the patient, every medical personnel should question and assure that they have satisfied the desires of the patient that have been displaced upon the patient-physician interaction. The medical educator is responsible for facilitating this dialogue that the student must have immediately after seeing a patient by asking loaded questions towards ascribed and perceived quality of action towards the wellbeing of the patient. The medical educator must ask questions like "How did you make the patient feel cared for" rather than questions prompting expository responses and not pushing the student to re-explore his internal process of coming up with the virtuous response.

Delayed reflections, on the other hand, prompt questions towards the motivations and desires the student holds in order to assure the fulfillment of his appetitive choices through rational and deliberative actions. Effectively, delayed reflections require the

[37] ref. *De Anima*, 701a8-12

student to reflect upon the methodology and nature of his coming to virtue and the effectiveness this process has in providing a virtuous response.[38] The medical educator may engage the student in a reflective conversation at the end of a clinical rotation; however, this reflection requires a lot more time and effort to understand. I recommend self-evaluations or reflective writing (e.g. diaries, reflective essays, etc.) to fulfill this requirement as it provides the student with more time and direct deliberation of one's motivations, desires, and actions in a cohort of clinical cases.

Thus, virtues can be taught in medical education. The lack of a standard of virtue does not preclude teaching virtue, but rather places into question the means of doing so. Given the model detailed above and derived from Aristotle's complete set of works, it is evident that virtue education is a practical addition to the medical education. Granted that virtue assures the preparation of medical students to function as fully competent physicians trained to care for the patient's needs, virtue education is a requirement for improving the healthcare system and amending the patient-physician relationship, as will be further detailed in the next chapter.

[38] ref. *On Memory and Recollection*, 452a27

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CHAPTER FOUR

Understanding How Virtue-Based Practice Will Amend the Modern Medical Crisis

With the advent of the Patient Protection and Affordable Care Act (PPACA), a new era of heath care has begun.[1] The changes and revisions associated with this law increase the complexity of both patient care and the larger health care system. Health care will continue to receive higher levels of scrutiny as it must provide high-quality, patient-centered, systems-based care with new and often limited resources.[2] The community and patient population will continue to expect high level of care from practitioners and healthcare organizations, which increases the burden placed on the provider, who does not have an adequate training in virtuous care under the modern medical school education curriculum.[3]

The new healthcare era brings about issues that are often exceedingly complex in terms of cost, ethics, and means of practice. In addition to understanding the technical aspects of medical practice, healthcare providers must also consider infrastructural demands (efficiency, reimbursement rates, market virtues, etc.) while satisfying the stringent expectations regarding ethics and virtuous practice. Granted, virtue education

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[1]ref. Protection, P., & Act, A. C. (2010). Public Law 111-148. *Title IV, x4207, USC HR*, *3590*, 2010.

[2] Siu, A. L., Bibbins-Domingo, K., & Grossman, D. (2015). Evidence-based clinical prevention in the era of the Patient Protection and Affordable Care Act: the role of the US Preventive Services Task Force. *JAMA*, *314*(19), 2021-2022.

[3] Kantarjian, H. M., Steensma, D. P., & Light, D. W. (2014). The Patient Protection and Affordable Care Act: Is it good or bad for oncology?. *Cancer*,*120*(11), 1600-1603.

will not resolve the infrastructural demands of medical practice given from hospital systems, state regulation, and federal regulations, it will serve as a means of addressing patient interests in a fashion that satisfies the patients motives alongside resolving the health issues at-hand.[4] Infrastructural demands will be addressed by federal mandate, laws, and hospital reform and will not be discussed further.[5] Rather, this chapter will address the need to balance the obligations placed on the healthcare provider through the virtue ethics perspective.

Because different principles in virtue and ethics conflict, it is not possible to practice in the healthcare profession for long without encountering some form of a dilemma. For example, many interventions involve harm (contrary to the *primum non nocore* ideology in medicine) yet provide a benefit in the long run, bringing up the question of whether the ends (patient benefit) justify the means (harm in the process). The modern healthcare provider must be able to explain the relative benefits and risks to the patient and then cooperate with the patient to formulate a treatment plan. This process, however, must transcend the evidence-based medicine approach such that the physician can provide honest input towards the "harm" involved without interjecting bias rhetoric to sway the patient towards their preferred intervention plan.[6]

One virtue principle alone may create conflict given situational and relativistic conflicts. Take the virtue of truth; physicians must know how to tell the truth to patients.

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[4] Brown, M. M., Brown, G. C., Sharma, S., & Landy, J. (2003). Health care economic analyses and value-based medicine. *Survey of ophthalmology*,*48*(2), 204-223.

[5] Eisenberg, J. M. (2001). What does evidence mean? Can the law and medicine be reconciled?. *Journal of Health Politics, Policy and Law*, *26*(2), 369-381.

[6] Summers, J. (2009). Theory of healthcare ethics.

Even though information can be regarded as therapy, information delivered at the wrong time or in the wrong manner can be devastating, given the situational biases and construals that the patient brings in to their understanding. Likewise, information not delivered at the right time or at all will definitely be construed as dishonest and further the lack of trust the patient has for the physician and subsequent decline in the patient-physician relationship being formed.[7] Further, the decline in one patient-physician relationship inherently effects the formation of others as patient distrust towards physicians becomes a bias shown through negative construals of information given by other physicians.[8] Thus, learning how to deal with these issues effectively takes some form of practical wisdom (*phronesis*) and rational deliberation (*prohairesis*) to compliment the theoretical (*scientia*) and practical knowledge (*techne*) the healthcare provider must provide to the patient.

A major component of the patient-physician relationship is the patients' trust that their healthcare providers have their best interest at heart and that they are competent. If patients perceive healthcare providers as individuals of integrity, virtue, and practical wisdom, then their confidence in the healthcare providers will increase. That increase in patients' confidence has been empirically shown to enhance patients' perceived health through the placebo effect.[9] Healthcare providers who know how to exemplify these virtues and promote trust embody the virtuous physician, especially in terms of practicing

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[7] Cabot, R. A. (1978). The use of truth and falsehood in medicine.

[8] Wu, A. W., Cavanaugh, T. A., McPhee, S. J., Lo, B., & Micco, G. P. (1997). To tell the truth. *Journal of General Internal Medicine*, *12*(12), 770-775.

[9] Justice, B. J. (1988). Who Gets Sick. How Beliefs, Moods, and Thoughts Affect Your Health. Jeremy P Tarcher. *Inc. Los Angeles*.

practical wisdom (*phronesis*) and personifying the AMA's *Principles of Medical Ethics*.[10,11]

Virtuous practitioners, which by proxy includes moral character and practical wisdom (*phronesis*), will be able to make appropriate decisions through effective rational deliberation (*prohairesis*) about the means to the ends. This has significant implications for clinical situationalism. When faced with situational challenges in health care, the virtuous physician will have the practical wisdom to know how to weigh the various issues and concerns of the patient and the hospital and form a conclusion that satisfies all the parties involved. However, virtuous physicians can, and will, come to different conclusions about the appropriate situational course of action due to different experiences guiding their practical wisdom and biases they hold that effect their construal, discernment, and response to the situation. Therefore, it is advised that virtuous physicians communicate and engage in some form of dialogue regarding ethical and situationally difficult cases, alongside their meta-approaches to general cases.

Healthcare organizations have sought to institutionalize the communication and dialogue between healthcare professionals by creating ethics committees, review boards, and forums between different healthcare personnel. The virtuous physician is seen to be ahead of most healthcare professionals and most industries in having a decades-long-tradition of what modern medicine calls ethics and virtue committees, virtue-ethics-laden consultations, institutional review boards (IRBs), and more. These modern administrative

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[10] Marcum, J. A. (2012). *The virtuous physician: the role of virtue in medicine*(Vol. 114). Springer Science & Business Media.

[11] Baker, R. (Ed.). (1999). *The American medical ethics revolution: how the AMA's code of ethics has transformed physicians' relationships to patients, professionals, and society*. JHU Press.

mechanisms make it "easier" to manage disagreement.[12,13] Nonetheless, the key here is that individuals of good character, pursuing virtuous ends, and embodying the virtue framework in practice are much more likely to make an appropriate choice that those without such experience or character. Though we cannot rapidly change the experience a physician brings forth, we can habituate character through the virtue education model proposed in chapter three.

It is important to note that choices made through the above process refute one of the usual criticisms levied against virtue-ethics and virtue theory. Critics claim that there is no clear way to resolve disputes when virtuous individuals disagree about the correct course of action.[14,15] Communication avenues and infrastructural mechanisms such as ethics committees, IRBs, and intra-professional consultations lead virtuous practitioners to become deliberators, who make a decision, even though it may not be unanimous.[16]

When it comes to virtue implementation, it is fair to say that health care has a major advantage over many other fields in that is has a longer educational process and greater chance to integrate some form of character habituation and virtue development. In doing so, the purpose of the educational process must include the development of a cadre

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[12] Fost, N., & Cranford, R. E. (1985). Hospital ethics committees: administrative aspects. *Jama*, *253*(18), 2687-2692.

[13] Swenson, M. D., & Miller, R. B. (1992). Ethics case review in health care institutions: committees, consultants, or teams?. *Archives of Internal Medicine*, *152*(4), 694.

[14] Irwin, T. H. (1988). Disunity in the Aristotelian virtues.

[15] Sreenivasan, G. (2009). Disunity of virtue. *The Journal of ethics*, *13*(2-3), 195-212.

[16] Menikoff, J. (2010). The paradoxical problem with multiple-IRB review. *New England Journal of Medicine*, *363*(17), 1591-1593.

of elite virtuous professionals, such that healthcare students become individuals of high virtuous character in Aristotle's spectrum.

Virtue ethics in medicine thus requires that the individual be habituated in a manner that puts the patient's interests first in times of situational difficulty, such that the *Good* of medicine (i.e. the patient's wellbeing) is addressed as a primary factor in all decision-making. As an effect the virtuous physician must respect the patient's wishes, even if they do not agree with those wishes. Consider the case below:

> Case 1: *Patient A was a 62-year-old woman who developed stage 2 chronic kidney failure (furthering to CKD) in her late teens secondary to mesangiocapillary glomerulonephritis. Her condition worsened and she had a live donor kidney transplant aged 34, which failed 13-years later and a cadaveric transplant the year after lasting 8 years. Her past medical history included hypertension, acute myocardial infarction, and a cerebrovascular accident. After 5 years of hemodialysis following the failed cadaveric transplant, the idea of withdrawing from active therapy was discussed at a time she described as "the low point in my life." Psychiatric care through this period had no effect on her functional state. She reiterated her desire to withdraw from therapy, because of the combination of physical symptoms of recurrent brachiocephalic thrombosis, nausea, vomiting, and a decline in overall functional status. In hope of a third donor kidney, Patient A's nephrologist encourages her to stay on hemodialysis and fight through the symptoms rather than giving up; however her care team still discusses the option of palliative care. Topics in quality of life were raised and a joint decision was made to continue management through a palliative care setting. This family meeting, along with ongoing follow-ups with the renal team reinforced the relationship where Patient A felt that she was supported in her decision to discontinue dialysis therapy. An interdisciplinary approach was facilitated by referrals to social work and pastoral care. Patient A passed away in full sedation, shortly after refusal of hemodialysis.*[17]

In Patient A's case, early predialysis education, which reinforced a palliative approach, helped to ensure that both the patient and family had no misconceptions about

[17] Koshy, A. N., Mace, R., Youl, L., Challenor, S., Bull, R., & Fassett, R. G. (2012). Contrasting approaches to end of life and palliative care in end stage kidney disease. *Indian Journal of Nephrology*, *22*(4), 307–309. http://doi.org/10.4103/0971-4065.101263

the prognosis or the efficacy of renal replacement therapy. A planned decision to stop dialysis ensured a timely referral to a multidisciplinary palliative care setting and a “good death” of Patient A, viewed by both the patient and those around her. This outcome may have been achieved even without palliative care, but it most likely had a significant impact.

Patient A's death, through unfortunate, warrants re-assuring connotations, as we know she died in peace and with dignity. The reduction of the disconcerting emotions given by the death scenario arise from the fact that Patient A received virtuous care. Her physician, hopeful of a third transplant, educates Patient A of her options and respects her choice for palliative care, though he does not agree with the choice. His rhetoric in educating Patient A was such that it did not dissuade the patient to one option or the other, but rather allowed the patient the full autonomy on her treatment plan. This is not to say that the physician was passive in care. As a virtuous physician, he still provided a recommendation, based on his experience and practical wisdom; however, he did not put forth a negative construal of palliative care as another option. In doing so, the virtues of respect, honesty, and trust easily arise and provide Patient A's immediate family the ability to appreciate the quality of care provided by the virtuous physician and thus enhance the patient-physician relationship, by showing virtuous care that will subconsciously play a role in positively construing relationships with other physicians alike.

Next, consider how the virtue of empathy is altruistically applied by the physician throughout the entire healthcare process.[18] Patient A's physician recommends curative care initially, as he has already established the relationship with Patient A to understand her motivations and desires. Patient A, however, has begun to decline in mental health and feels discouraged to continue treatment, which acts to negatively construe the situation. Most physicians would passively accept Patient A's negatively construed desire to end curative care, as they see that as the empathetic action, but that action is submissive to situation factors, rather than sincerely intrinsic desires that motivate ones actions. As an empathetic and altruistic practitioner, the virtuous physician knows the patient's motivations and situational biases from the strong relationship he pursues.[19] His relationship with the patient guides his understanding of the patient throughout care, as he is able to displace his personal motives and address the deepest convictions of his patient. He remains loyal to the patient's convictions, even when the patient cannot, while also considering how the technical sciences and evidence-based practice can benefit the patient. In this case specifically, the virtuous physician knew about high efficacy HLA-incompatible transplants and improvements in the maintenance of post-transplant health, such that a third and final transplant could dramatically increase the patient's quality of life and that her wait-time for a transplant is significantly lower under the new

[18] Batson, C. D. (2013). of Empathy-Induced Altruism. *Social psychology and economics*, 281.

[19] Burks, D. J., & Kobus, A. M. (2012). The legacy of altruism in health care: the promotion of empathy, prosociality and humanism. *Medical education*,*46*(3), 317-325.

procedure.[20,21] Thus, the empathetic action would be to initially support curative care by educating the patient with most up-to-date options, and then consulting the family, care-team, and patient on what their final wishes are. This way, the patient can be displaced from their negative dispositions through education and is re-motivated towards their initial convictions towards happiness and pursue a form of discourse that properly achieves that end.

Unfortunately, this is not the case with most modern healthcare interactions. More often than we hope for, patients experience the non-virtuous case, given below:

> Case 2: *Patient B was a 65-year-old woman who developed end-stage (stage 5) kidney disease (ESKD) secondary to diabetic nephropathy, managed with hemodialysis for 5 years. She was a bilateral amputee due to peripheral vascular disease, had hypertension, congestive heart failure, a history of vascular dementia, and a cerebrovascular accident. She lived at home with her husband who was her full time caregiver assisting her in all her activities of daily living. In this case, there were no discussions regarding palliative care documented on initiating dialysis or during the latter phases of treatment. The patient's sole support was her husband who was not well informed about the possible outcomes, prognosis and role of dialysis in ESKD. In several instances it was documented that he believed stopping dialysis was equivalent to "pulling the plug." These unrealistic expectations on his behalf lead to disagreements and sub-optimal care delivery. On her last in-hospital admission, the nephrologist made the decision to withdraw dialysis on medical grounds, as further dialysis was unlikely to lead to any improvement in patient comfort or survival. During this admission, the decision was made to feed the patient only as tolerated and the family filed a formal complaint as they felt that the hospital was trying to starve the patient. Palliative care assessment and review was only initiated a week prior to her demise and their suggestions of achieving effective sedation and managing the pain were not well received by the patient's family.*[17]

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[20] Montgomery, R. A., Warren, D. S., Segev, D. L., & Zachary, A. A. (2012). HLA incompatible renal transplantation. *Current opinion in organ transplantation*, *17*(4), 386-392.

[21] Orandi, B. J., Luo, X., Massie, A. B., Garonzik-Wang, J. M., Lonze, B. E., Ahmed, R., ... & Dunn, T. B. (2016). Survival Benefit with Kidney Transplants from HLA-Incompatible Live Donors. *New England Journal of Medicine*, *374*(10), 940-950.

In stark contrast to Patient A, Patient B's case was one where the lack of early and ongoing patient and family education about withdrawal from dialysis lead to the breakdown in communication and unrealistic expectations regarding treatment outcomes. Considering her poor functional status and multiple comorbidities, an earlier discussion with family regarding offering palliative care support and discussions regarding withdrawal of dialysis therapy could have potentially avoided such a turbulent end of life situation.[22]

The inherent distrust that developed between the patient's family and the health professionals led to a turbulent end of life situation that could have potentially been alleviated with counseling and palliative care involvement at an early stage.[23] However, an alternative intervention like this only comes with patient education and virtuous care. Upon reflection of Case 2, it is important to note the lack of education of alternative care models provided to Patient B's family. There is a lack of honest communication, patient and family autonomy, and trust in the case scenario which leads to vicious and incontinent care. This care perpetuates the negative stereotypes and biases that patient hold against physicians and healthcare and leads to a decline in the patient-physician relationship. Family members remember the quality of care, or lack thereof, and build a

[22] Evans, R. W., Manninen, D. L., Garrison Jr, L. P., Hart, L. G., Blagg, C. R., Gutman, R. A., & Lowrie, E. G. (1985). The quality of life of patients with end-stage renal disease. *New England Journal of Medicine*, *312*(9), 553-559.

[23] Johnson, J. P., McCauley, C. R., & Copley, J. B. (1982). The quality of life of hemodialysis and transplant patients. *Kidney International*, *22*(3), 286-291.

negative bias that they displace in their construal of physicians in general and the healthcare system as a whole.[24,25,26]

Again, when we examine empathy and altruism in Case B, we see the incontinent, almost vicious, actions of the non-virtuous physician. It is evident that Patient B's physician is apathetic towards the well-being of his patient. Whether that stems from institutional day-to-day pressures or a lack of desire to help his patient (i.e. the *Good*) would determine his place in the Aristotelian spectrum of character. Nonetheless, his blatant disregard for Patient B's wellbeing is what must be addressed and amended through virtue education. If Physician B were trained in some form of altruistic perception, he would have the ability to empathize with the patient and communicate in a means that promotes the ends of understanding the patient's convictions, motivations, and desires. In doing so, Physician B would have also been able to show Patient B respect and dignity with her care, as the physician would have acted in accordance to the patient's wishes and desires. Not to mention the fact that Physician B's non-virtuous actions play a negative role in the bereavement process of Patient B's husband, the sole personal care

[24] Epstein, R. M., Franks, P., Fiscella, K., Shields, C. G., Meldrum, S. C., Kravitz, R. L., & Duberstein, P. R. (2005). Measuring patient-centered communication in patient–physician consultations: theoretical and practical issues. *Social science & medicine*, *61*(7), 1516-1528.

[25] Kim, M. S., Klingle, R. S., Sharkey, W. F., Park, H. S., Smith, D. H., & Cai, D. (2000). A test of a cultural model of patients' motivation for verbal communication in patient-doctor interactions. *Communications Monographs*,*67*(3), 262-283.

[26] Mühlbacher, A. C., & Juhnke, C. (2013). Patient preferences versus physicians' judgement: does it make a difference in healthcare decision making?. *Applied health economics and health policy*, *11*(3), 163-180.

provider, which has significant implication in the perpetuation of negative biases and stigmas against the U.S. healthcare system and physician practice.[27]

Thus, there is a major need for virtue education in medical schools to establish a framework of virtuous practice and ground virtuous character in future practicing physicians. In doing so, physicians can profoundly affect the view of healthcare held by most patients and directly thwart the decline in the patient-physician relationship. In doing so, physicians can better address the health of their patients and promote the ends of medicine, patient wellbeing. This increase in overall health of the United States population would inherently relieve stresses placed on the medical infrastructure in terms of cost, access, and trust leading to an improvement in the overall U.S. healthcare system. Therefore, virtuous practice, as given by proper virtue education, can directly counteract the decline in the patient-physician relationship and has major implications for improving any healthcare system that adopts the virtuous model.

[27] Wright, A. A., Zhang, B., Ray, A., Mack, J. W., Trice, E., Balboni, T.& Prigerson, H. G. (2008). Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *Jama*, *300*(14), 1665-1673.

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CHAPTER FIVE

The Maintenance of Virtue in Medical Practice through Infrastructural Reform and A Call for the Virtue-based Future

It is evident that virtue must be an integral part of medical education. The issue that then arises is how to maintain virtuous practice following the educational process. Though the virtuous physician is grounded in a desire for the patient's good through virtuous means, we can not preclude that modern social and infrastructural challenges will not lead the physician to abandon virtue and practice political, defensive, non-virtuous medicine.[1] Thus, this chapter will propose a practical means of promoting and maintaining virtuous practice and of calling for a virtue-based future of medical practice.

Virtue education teaches self-reflection and promotes positive coping mechanisms that are characteristic of resilient and passionate individuals. The education process utilizes challenging personal narratives from trained faculty and clinical role-models to promote reflection and growth in the context of the moral complexities associated with all facets of medical practice.[2,3] Again, the future physician is habituated in moral

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[1] Shah, N., Marcum, J.A.. (2015). Can Virtues be taught in Medicine? Aristotle's Virtue Theory and Medical Education and Clinical Practice. *Mirabilia Medicinae*, *4*(1), 10–22.

[2] Cruess, R. L., Cruess, S. R., Boudreau, J. D., Snell, L., & Steinert, Y. (2014). Reframing medical education to support professional identity formation. *Academic Medicine*, *89*(11), 1446-1451.

[3] Leonardo Seoane, Lisa M. Tompkins, Anthony De Conciliis, and Philip G. Boysen (*2016*) Virtues Education in Medical School: The Foundation for Professional Formation. The Ochsner Journal: Spring 2016, Vol. 16, No. 1, pp. 50-55.

character to be virtuous and guided through critical thinking avenues to achieve the ends of medicine through virtuous practice in construal, perception, and situational discernment.[4]

To ensure the maintenance of virtue in practice following the lengthy medical education process, it is important to put forth infrastructure to assure that the virtuous grounding that physicians obtain is not lost to systemic pressures like time-constraints, malpractice, and efficiency measures. Thus, I will discuss a practical means of retaining virtuous practice through systemic measures. I propose that the measurement and dissemination of health outcomes should become mandatory for every provider and every medical condition. Virtuous practice will lead to better health outcomes, patient perspectives toward personal healthcare, and lower incident rates of malpractice, as argued in the former chapters and in modern literature, thus leading to higher scores on health outcome and patient perspective surveys.[5] Additionally, the results not only will drive providers and health plans towards improving outcomes and efficiency, but will also help patients and health plans choose the best provider for their medical circumstance, which integrates a means of demand-side rationing to our current supply-side rationing healthcare system.

It is important to note the nature of the patient outcome and what that entails. Outcomes of care are inherently multidimensional, including not only survival, but also the degree of recovery, promotion of well-being, time of recovery, discomfort of care,

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[4] Sherman, N. (1989). The fabric of character: Aristotle's theory of virtue.

[5] Hibbard, J. H., & Greene, J. (2013). What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. *Health affairs*, *32*(2), 207-214.

and the sustainability of the recovery process.[6,7,8] Thus, outcomes must be measured over the entirety of the healthcare process for a patient, rather than on a case-by-case basis. Additionally, outcomes must be adjusted for a patient's initial conditions to eliminate bias against patients with complex cases, as they would skew the outcome rate in a negative manner.[9] Healthcare analyst need to measure "true" health outcomes, rather than relying solely on infrastructural measures such as compliance with practice guidelines, which are inherently slow to change and incomplete in nature, which is counter-productive to an evidence-based practice.[10] Analyst also need to stop using just a few measures as a proxy for a provider's overall quality of care.

As a long-term move towards resolving issues in the U.S. healthcare system, an active involvement of the federal government will be necessary to ensure universal, consistent, and fair measure throughout the country. Again, government intervention, as a "top-down" regulatory process will take time to implement fully. Thus, a preemptive verbal federal mandate is necessary, requiring every provider team to report its

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[6] Wernicke, Mark. (2016) A proposed set of metrics for standardized outcome reporting in the management of low back pain. *Acta Orthopaedica* 87, 88-90

[7] Raleigh, V. S., Frosini, F., Sizmur, S., & Graham, C. (2012). Do some trusts deliver a consistently better experience for patients? An analysis of patient experience across acute care surveys in English NHS trusts. *BMJ quality & safety*, *21*(5), 381-390.

[8] Starr, R. (2015, October). I. Patient surveys for quality assessment: Review of insights and best practices. In *143rd APHA Annual Meeting and Exposition (October 31-November 4, 2015)*. APHA.

[9] Reeves, R., West, E., & Barron, D. (2013). Facilitated patient experience feedback can improve nursing care: a pilot study for a phase III cluster randomised controlled trial. *BMC health services research*, *13*(1), 259.

[10] Montori, V. M., Brito, J. P., & Murad, M. H. (2013). The optimal practice of evidence-based medicine: incorporating patient preferences in practice guidelines. *Jama*, *310*(23), 2503-2504.

experience or the volume of patients treated for each medical condition, along with the intervention plan utilized. Experience reporting by a healthcare provider will help patients and their physicians find providers with expertise that meets their needs, again implementing characteristics of demand-side rationing in the healthcare marketplace.[11,12]

I also propose the addition of more virtue-based continued education options. In the United States, 46 states require non-category 1 Physician Recondition Award (PRA) continuing education to maintain state licensure to practice. States not included, and therefore not applicable for this additional means of promoting and maintaining virtuous practice, are Colorado, Indiana, Montana, New York, and South Dakota.[13] The addition of virtue-based continued education options, namely virtue retreats, seminars on virtues, and virtue-laden conferences would allow for the re-grounding of the reflective nature of virtue implementation in medical practice. Physicians will be provided the opportunity and support to engaging in dialogues with other physicians, regarding clinically difficult situations, both in case study and in infrastructural stressors. Additionally, clinical role models will be present to facilitate and guide discussion on the virtuous action and reaction in clinical scenarios. These role models also have the ability to re-habituate moral character and re-instill virtuous critical thinking skills that promote proper

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[11] Fenton, J. J., Jerant, A. F., Bertakis, K. D., & Franks, P. (2012). The cost of satisfaction: a national study of patient satisfaction, health care utilization, expenditures, and mortality. *Archives of internal medicine*, *172*(5), 405-411.

[12] Shi, L., & Singh, D. A. (2015). *Essentials of the US health care system*. Jones & Bartlett Publishers. 115-138.

[13] Physician's Recognition Award and Credit System. (2015). Retrieved March 28, 2016, from http://www.ama-assn.org/ama/pub/education-careers/continuing-medical-education/physicians-recognition-award-credit-system.page?

discernment of the clinical situation, thus maintaining the virtuous model of care.[14] This methodology is both quick in implementation and systematically integrated into the modern healthcare system as a whole.

The main issue at-hand with the continuing education model of enforcing the maintenance of virtuous practice is the voluntary basis that physicians not required to take non-category 1 Physician Recondition Award (PRA) continuing education for licensure must take.[13] I respond to this criticism by referring back to the nature of the virtuous physician, himself. The virtuous physician desires the promotion of the *Good* (or the patient's wellbeing) or as Aristotle calls it *epithumia*. The virtuous physician also knows the means necessary to achieve the ends of the Good through *prohairesis* and *praxis*. Subsequently, by nature the virtuous physician is drawn towards continuous education towards virtue, whether the virtuous physician has an infrastructural requirement to act towards continuous education or not.

So, the physician is inherently and systematically called back to the retention of virtuous practice and incentivized through positive market feedback loops to maintain virtue in practice by the outcome benefits and patient perspective that determine the physician's efficiency and effectiveness. Hence, there is a call for virtue in medical practice, originating from the grounding of construal and character-based virtues in medical education.

In conclusion, there is both value and necessity to a virtue education in the medical curriculum, especially through the Aristotelian pedagogy. Virtues are the foundation of a modern professional formation. They provide a groundwork for

[14] Sanderse, W. (2013). The meaning of role modelling in moral and character education. *Journal of Moral Education*, *42*(1), 28-42.

physicians to maintain humanistic practice and they navigate an increasingly complex medical system. When physicians are distanced from themselves and from virtues like empathy and altruism, the patient is sure to suffer. This potential impact is against the good of medical practice and warrants the need for discussion of key virtues in practical clinical scenarios, preceding actual clinical encounters where the outcome of the patient is at risk of the virtuous judgment calls of the practitioner. Again, the grounding and quick application of virtuous thinking, rather than a standard of deontological rules or explicit virtues, is what the virtuous education strives for. With inadequate training in the virtues, medical students and future medical practitioners run the risk of learning the wrong lessons from the informal curriculum, as they encounter corporate medicine, infrastructural stressors, and negative role-modeling.

Thus, I put forth a call for an education in virtue as a necessity to counteract the growing complexities of modern and future medical practice and assure the growth in positive patient outcomes and perceptions towards the medical field in general. I call for the integration and training of virtues for medical educators and clinical practitioners. I call for a contemporary Flexner-like report, mandating the systematic integration of a virtue pedagogy in medical education, preferably as given by Aristotle in his complete set of works. I call for infrastructural reform to assure the maintenance of virtue practice following the education of the virtuous physician. But most of all, I call for universal virtuous practice in the contemporary medical field, as the social, fiscal, and structural benefits of virtue-based practice put forth a potentially revolutionary means of improving healthcare on a national and global scale. For not to pursue virtue is to give into vice.

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