Ch. 2: How to Cultivate Virtues and Develop Moral Character

Brendan's Big Book of Bioethics | Brendan Shea, Ph.D. (Brendan.Shea@rctc.edu)

1 CONTENTS

2 WE CARE A LOT: AN INTRODUCTION TO THE VIRTUES

In this lesson, you'll be learning to:

1. Define moral virtues, and explain how they relate to professional roles in medicine.
2. Explain the tension between an "ethics of care" and an "impartial ethics."
3. Describe the "Five Focal Virtues" of caring.

According to Beauchamp and Childress *Principles of Biomedical Ethics* (2020, B-C from here on out), a **moral virtue** can be defined as a "dispositional trait of character that is morally valuable and is reliably present in a person." In more straightforward language, we might say that a moral virtue consists of a *habit* of doing the right thing, for the right reasons, and with the right attitude. The common morality recognizes many virtues, including generosity, courage, and kindness. Being virtuous is not the same as simply "following the rules," since a person may be virtuous without knowing each and every rule (but simply may "feel" the right thing to do). Conversely, a person who follows the rules may not be virtuous (for example, if they only do so to get a reward or avoid punishment).

A few definitions may help in making clear the importance of virtues in health care: Every **professional role** ("physician," "nurse," "surgeon," "radiographer") is associated with specific standards tied to **professional practice.** These standards are closely associated with both moral and non-moral virtues. For example, being a "good physician" requires that one be knowledgeable about medicine, have good leadership skills, and be capable of weighing the evidence relevant to diagnosis. Being a "good nurse" requires that one be able to advocate for patients and interact well with other members of a medical team. Both physicians and nurses must relate well to patients and act with integrity.

Some of these standards are **standards of technical performance,** which are tied to *non-moral virtues***.** These include *technical skill* (for example, how well can you carry out various medical techniques?) and *judgment* (for example, how good are you at figuring out which approach to use in a particular case?). Other standards are **standards of moral character,** which are tied to *moral virtues.* These include *normative* skills (for example, how compassionate and conscientious are you?). In most professions (and in health care, in particular), people are much more forgiving of mistakes related to technical performance or judgment than of "moral errors."

2.1 WHAT IS CARING? HOW DOES IT RELATE TO IMPARTIALITY?

In health care professions, as in many other areas of life, a fundamental moral virtue is that of **caring,** which involves the "care for, emotional commitment to, and willingness to act on behalf of persons with whom one has a significant relationship." In particular, a "good" (or *virtuous*) health care professional should care about one's patients, and their behavior should reflect this. B-C defend a version of the **ethics of care,** which claims that caring is the *most important* moral virtue[1]. The other virtues we will discuss are supposed to represent different *aspects* of caring.

The "Ethics of Care". The ethics of care was formulated initially and defended by feminist philosophers, who had noticed that discussions of moral "obligations", "duties", and "rights" often tend to ignore the role that *caring relationships* play. For example, it is because of women's relationship with their children (historically, they were almost always the primary caretakers) that they have felt "morally obligated" to do more for children than did the fathers. The basic idea of the ethics of care is that, since morality is based on relationships, it is vital to ensure everyone has an equal opportunity to form valuable, caring relationships that allow them to develop as human beings.

Limitations on the Ethics of Care. While the ethics of care has been influential, several scholars have pointed out it can't be "the whole story" about ethics. In particular, critics of this approach have raised tow two concerns:

- **Is caring in conflict with impartiality?** While caring is critical, it can sometimes be in tension with the moral ideal of **impartiality** emphasized by many versions of religious and secular ethics. According to the standard of impartiality, a morally virtuous person should treat people *equally* and show *no favoritism* to friends, family, or themself (hence, the ideal of a saintlike person who leaves their family to go and help the truly needy).
    - For example, the Golden Rule ("treat others as you would like to be treated") is an example of an impartial moral rule, as is utilitarianism ("maximize the happiness of ALL beings"). Both principles imply we should not treat some people better/worse than others.
    - An ethics of care, by contrast, emphasizes that one *should* treat some people (such as friends, family, coworkers, and patients) differently than others.
- **Does the ethics of care overemphasize the role of emotion in making ethical decisions?** Impartial ethical theories often emphasize the idea that one should do the right thing "merely because it is the right thing to do" and not, for example, for "merely emotional reasons." The ethics of caring, by contrast, emphasizes that emotional connections (especially with patients in the context of medicine) can play an essential role in motivating us to do the right thing.

While there is no perfect formula for balancing caring vs. impartiality, or emotion vs. pure intellect, developing a moral character involves taking all of these competing (and morally relevant) issues seriously and learning to balance them.

2.2 WHAT ARE THE FOCAL VIRTUES? HOW DO THEY RELATE TO CARING?

Becoming a caring person requires *practic*ing several more "specific" virtues related to caring. In medicine, the following **focal virtues** are fundamental.

- **Compassion,** sometimes called the "prelude to caring**,"** consists of an "attitude of regard for another's welfare with an imaginative awareness and emotional response of sympathy, tenderness, and discomfort

[1] For an accessible introduction to the ethics of care, see Maureen Sander-Staudt, "Care Ethics," in *Internet Encyclopedia of Philosophy*, May 2019, https://www.iep.utm.edu/care-eth/.

at another's misfortune or suffering." It requires that one have *empathy* for the feelings of others AND that one act on this in an informed, productive manner. One must be careful so that one's compassion for others does not cause one to act in a way that is not consistent with the *other* virtues.[2].

- **Discernment** involves the "ability to make fitting judgments and reach decisions without being unduly influenced by extraneous considerations, fears, personal attachments, and the like." Discernment requires more than merely "knowing a lot of facts"—it requires you to use this knowledge *practical*ly to help patients.
- **Trustworthiness** requires that one act in a way that warrants "confidence in one's character and conduct." If your colleagues and patients trust you, they have confidence that you have good motives (e.g., you care about their well-being), appropriate feelings (e.g., their pain shouldn't make you happy!), and that you will follow the relevant moral norms.
- **Integrity** includes "objectivity, impartiality, and fidelity in adherence to moral norms." It involves (1) having a well-thought-out, internally consistent set of moral beliefs and (2) being willing to stand up for these beliefs when they are challenged. A person with integrity takes the demands of morality *seriously*. Patients and colleagues often appreciate and benefit from this, even if they may disagree with some of the specific moral beliefs in question. In some cases, there can be conflicts between *professional integrity* ("what you feel morally obligated to do *as a professional*") and *personal integrity* ("what you feel morally obligated to do *as a person*).
- **Conscientiousness** consists of being consistently "motivated to do what is right because it is right, [trying] with due diligence to do what is right, intend[ing] to do what is right, and exert[ing] appropriate effort to do so." Conscientious people think through tough moral decisions and are genuinely concerned about doing the right thing. Conscientious people will intuitively "feel" the need to obey moral norms and feel shame, remorse, and guilt if they recognize that their own conduct has violated these norms.

Historically, most medical codes of ethics have emphasized the importance of developing virtues (though the most recent AMA code does not). However, different virtues have been stressed by various codes. For example, early nursing codes emphasized obedience to *physicians* (even if they disagreed with the physician). In contrast, contemporary codes underline the obligation of caring for the *patient* (even if this leads to conflict with physicians).

2.3 QUESTIONS FOR REVIEW

Please answer the following questions.

1. Come up with an example of a (real or fictional) person you feel demonstrates the virtue of caring. (If possible, use an example from medicine). Then, assess the extent to which they instantiate the five focal virtues described above.
2. Do you agree that **moral errors** are often "worse" than **technical** or **judgment errors?** Why or why not?
3. To what extent do you think morality requires that we behave *impartially* (i.e., treat everyone equally, regardless

[2] For an interesting discussion of empathy, and the potential p
parents, educators, and medical professionals) often think of it
Review, September 10, 2014, http://www.bostonreview.net/fo

of your personal relationship with them)? Explain and defend your answer.

4. Which aspect(s) of caring do you think it would benefit you personally to work most on improving (especially as this relates to your work life)? Why? Explain and defend your answer, referencing the "Five Focal Virtues" where appropriate.

3 WHAT IS THE DIFFERENCE BETWEEN OBLIGATIONS AND IDEALS?

In this lesson, you'll be learning to:

Figure 1 Nurse with a sick child (Brendan Shea x Dall-E).

1. Distinguish between morally neutral, morally obligatory, and supererogatory actions, and give examples.
2. Describe the moral ideals of moral saintliness and moral heroism, and discuss their importance in moral life.

3.1 GOING BEYOND WHAT'S REQUIRED: SAINTS AND HEROES

So far, we have primarily discussed **moral obligations**—the sorts of norms that morally good people must adhere to and the virtues that *all of us* ought to try and develop. By contrast, **moral ideals** involve actions and attitudes that are morally admirable but are NOT required. These ideals are closely linked to **supererogatory actions** that

(1) are neither forbidden nor required by the common morality (e.g., it is neither required nor prohibited by the common morality that one donate bone marrow to a stranger),
(2) exceeds what the common morality requires of us (e.g., common morality might require that we donate bone marrow to help a sibling or child; donating to a stranger *exceeds* this requirement),
(3) done intentionally to help other people (e.g., you are donating bone marrow *to* help a stranger), and
(4) are morally commendable in and of themselves (e.g., since donating bone marrow really does help others, a donor has done *more* than merely "shown how much they care" or "shown a willingness to sacrifice").

In many cases, supererogatory actions would be morally required, except for the effort, risk, money, time, or pain involved. Because of this, actions that are supererogatory for some people (e.g., *I'm* not morally obligated to jump in front of a train to save a baby) might be ethically obligatory for other people (e.g., *Superman*, if he existed, might be morally required to save the baby). This suggests something like the following "scale" of moral obligation and supererogation.[3]:

Type	Subtype	Example
Morally Neutral	Doesn't matter	"I'm going to order soup instead of salad."

[3] For a detailed introduction to supererogation (and the philosophical debates around it), see David Heyd, "Supererogation," in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, Spring 2016 (Metaphysics Research Lab, Stanford University, 2016), https://plato.stanford.edu/archives/spr2016/entries/supererogation/.. For more on the psychology of moral heroism, see Ervin Staub, "Moral Courage, Heroism and Heroic Rescue," Psychology Today, accessed May 28, 2019, http://www.psychologytoday.com/blog/in-the-garden-good-and-evil/201203/moral-courage-heroism-and-heroic-rescue. Finally, for a *skeptical* take on the value of aiming at heroism, see Daniel Callcut, "Why It Is Better Not to Aim at Being Morally Perfect," Aeon, accessed May 28, 2019, https://aeon.co/essays/why-it-is-better-not-to-aim-at-being-morally-perfect.

Obligation	Strict Obligation	"I am strongly obligated not to throw my hot soup at the wait staff."
	Weak Obligation	"When I receive good service at a restaurant, I am weakly obligated to leave a tip."
Supererogation	Ideals Beyond the Obligatory	"It would be morally ideal if I took the time to fill out an evaluation praising the waiter's or waitress's excellent service since I know this will help him or her."
	Saintly and Heroic Ideals	"It would be saintly if I gave all my money (except the bare minimum needed to live) to fight world hunger, and thus never ate a restaurant again." "It would be heroic if I ran back into the burning building in an attempt to save the small child who is stuck."

Moral saintliness requires "regular fulfillment of duty and realization of ideals over time; it demands consistency and constancy." Moral saints include those who *regularly* take significant risks (working with victims of highly contagious infectious diseases) or undergo very high costs (moving to the poorest areas of the world) to serve their patients. By contrast, **moral heroism** involves a single exceptional action (such as risking death to achieve a professional or personal moral ideal). Examples of moral heroes relevant to medicine might include people responding to attacks or natural disasters when doing so puts them at personal risk. Heroes need not be saintlike; all that is required is that, at this moment, they went above and beyond.

3.2 What is Moral Excellence? Why Does it Matter for "Ordinary" People?

In the previous section, we suggested that we are NOT *morally obligated to* act heroically or to live like moral saints. However, this observation raises another question: "If we aren't obligated to act like heroes or saints, what's the point in even thinking about them? Why should I care about moral excellence?" Here are a few reasons:

- **It provides "moral education."** Focusing on what is morally *best* (and not just on what is morally *required*) can help us lead better personal and professional lives and strengthen essential relationships (with friends and family, patients, and even animals). People who aim for excellence (even if they never achieve it!) improve their own lives and those around them.
- **It helps us see that "being a better person" is possible.** It can often seem "impossible" or "superhuman" to aim for moral excellence. However, reflecting on the lives and actions of saints and heroes shows us that it is possible to lead a happy, productive life while *also* aiming for moral excellence. For example, many health professionals donate time and effort (and sometimes even their whole careers) to serving vulnerable populations. This means, for instance, that they often have to work long hours and accept less pay. However, these people generally report being perfectly happy with their choices, and still have families, cook dinner, enjoy movies and books, and so on. (In fact, most studies have suggested such people are actually *happier* than the rest of us, at least on average).
- **It broadens the scope of "morality" and "ethics."** When one just focuses on "doing the bare minimum, " it's easy to think that ethics isn't a big part of our professional and personal lives. Reflecting on moral excellence helps us to see that moral choices are *everywhere,* and that morality can provide a comprehensive framework for thinking about "what really matters" in life.
- **It provides a "measure" by which we can judge ourselves.** It's sometimes tough to evaluate our actions and lives, especially given the (relatively narrow) group of people with whom we regularly associate. Consciously considering the actions and motivations of moral saints and heroes can provide a concrete "yardstick" for evaluating how well *we* are doing.

3.3 QUESTIONS FOR REVIEW

1. Give an example of each of the following types of actions (besides those mentioned above): (a) morally neutral actions, (b) morally obligatory actions, and (c) supererogatory actions, and (d) heroic or saintly ideals.
2. Give an example of a person that you would consider a moral hero or moral saint. Explain your answer.
3. Many medical professionals say that they *distrust* healthy adults who volunteer to donate an organ (such as a kidney) to a complete stranger. Why do you think this is? How do you think medical professionals *ought* to respond when patients desire to do something like this?

3.4 BIOETHICS AND THE LAW: MCFALL V SHIMP[4]

"Plaintiff, Robert McFall, suffers from a rare bone marrow disease and the prognosis for his survival is very dim, unless he receives a bone marrow transplant from a compatible donor. Finding a compatible donor is a very difficult task and limited to a selection among close relatives. After a search and certain tests, it has been determined that only defendant [Shimp] is suitable as a donor. Defendant refuses to submit to the necessary transplant, and before the court is a request for a preliminary injunction which seeks to compel defendant to submit to further tests, and, eventually, the bone marrow transplant.

…The question posed by the plaintiff is that, in order to save the life of one of its members by the only means available, may society infringe upon one's absolute right to his "bodily security"?

The common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue. A great deal has been written regarding this rule which, on the surface, appears to be revolting in a moral sense. Introspection, however, will demonstrate that the rule is founded upon the very essence of our free society. It is noteworthy that counsel for the plaintiff has cited authority that has developed in other societies in support of plaintiff's request in this instance. Our society, contrary to many others, has as its first principle, the respect for the individual, and that society and government exist to protect the individual from being invaded and hurt by another. Many societies adopt a contrary view which has the individual existing to serve the society as a whole. In preserving such a society as we have, it is bound to happen that great moral conflicts will arise and will appear harsh in a given instance. In this case, the chancellor is being asked to force one member of society to undergo a medical procedure which would provide that part of that individual's body would be removed from him and given to another so that the other could live. Morally, this decision rests with the defendant, and, in the view of the court, the refusal of the defendant is morally indefensible. For our law to compel defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.

This request is not to be compared with an action at law for damages, but rather is an action in equity before a chancellor, which, in the ultimate, if granted, would require the forceable submission to the medical procedure. For a society which respects the rights of one individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for another member, is revolting to our hard-wrought concepts of jurisprudence. Forcible extraction of living body tissue causes revulsion to the judicial mind. Such would raise the spectre of the swastika and the Inquisition, reminiscent of the horrors this portends."

Questions

[4] McFall v. Shimp, 10 Pa. D. & C. 3d 90 (Court of Common Pleas 1978).

(1) The court held that Shimp was not legally required to donate bone marrow to McFall, even if this was the only way of saving McFall's life. Do you agree with the court's decision? Why or why not?
(2) As a matter of personal morality, do you think that Shimp was obligated to donate bone marrow? Why or why not?

4 SUFFERING, COMPASSION AND 'DOING GOOD MEDICAL ETHICS' (BY PAQUITE DE ZULUETA)[5]

ABSTRACT. 'Doing good medical ethics' involves attending to both the biomedical and existential aspects of illness. For this, we need to bring in a phenomenological perspective to the clinical encounter, adopt a virtue-based ethic and resolve to re-evaluate the goals of medicine, in particular the alleviation of suffering and the role of compassion in everyday ethics.

A young woman is rushed into hospital by ambulance to the labour ward. She is 28-weeks pregnant and alone. Her waters have broken, and she says she cannot feel the baby moving. The midwives cannot detect a heartbeat. They deliver her baby rapidly and competently. A paediatrician and a medical student are also present. The baby emerges stillborn and grossly deformed, his body bloated and his head misshapen. A dark swelling protrudes from his chest. After rapid delivery of the placenta and checking that the mother is physically stable and comfortable, the baby is whisked away to a side room. The clinical team cluster around the lifeless body, whispering instructions and counter instructions. Horror hangs in the air. Meanwhile, the woman, plump and helpless, lies on the bed— marooned, alone, tears slowly coursing down her cheeks. The student looks up and sees this. She detaches herself from the group and hesitantly approaches the woman. She gently takes the woman's hand lying limply by her side. No words are spoken. The woman squeezes the student's hand in silent gratitude.

4.1 INTRODUCTION

This narrative is one of many I partook in as a medical student and junior doctor which showed me the unintended harm that doctors and nurses could do to patients in their emotionally laden responses. I witnessed doctors getting angry, blaming or insulting patients, being cold and callous, lying, failing to explain, being patronising or simply not noticing distress or not listening to what patients were telling them. I also witnessed kindness, tolerance, patience and sensitivity. These observations, perhaps oddly, gave me the strong motivation to study and later to teach medical ethics. At that time ethics was not part of the medical school curriculum. We learnt from our role models, from hearing their deliberations, but above all what they said and how they behaved in their encounters with patients, colleagues and students. In the above narrative, one could perhaps fault the clinicians for not carrying out a specific duty or protocol, but what stood out for me was the lack of attentiveness to the woman's desolation and suffering. The shock—disgust even—generated by the abnormal stillborn baby eclipsed their sensitivity towards her plight. Instead they focused on carrying out correct forensic procedures. I have a recollection of timorously trying to comfort her and of feeling that this was the right thing to do. My teachers did not prescribe it and arguably I was 'stepping out of line. I certainly was not doing anything 'medical'. I could not bring back her baby from the dead, but I could at least offer a gesture of companionship, of comfort, as a fellow human being.

[5] Paquita C. de Zulueta, "Suffering, Compassion and 'Doing Good Medical Ethics,'" *Journal of Medical Ethics* 41, no. 1 (January 1, 2015): 87–90, https://doi.org/10.1136/medethics-2014-102355.

I give this example precisely because it does not represent a 'challenging ethical dilemma', yet undoubtedly was an event that the woman will never forget—nor, I suspect will she forget how those around her treated her. I would like to think that callous or unkind behaviour in healthcare is something of the past, but alas, the evidence from a variety of sources—anecdotes, the media, as well as from published narratives, formal inquiries and academic papers suggest otherwise. I propose that for the scholarship of medical ethics to translate into good ethical medical practice, it has to attend more closely to everyday ethics and the clear and uncontroversial goal of medicine: the relief of suffering. Furthermore, medical ethics has to be placed within a philosophical framework that 'works' in the context of the lived experience of patients and clinicians. This, I will argue, is best served by the restoration of virtue ethics, bringing in a phenomenological perspective to clinician-patient encounters, including narrative and imagination, and acknowledging the value of emotions in clinical– ethical decisions and responses. We need to remind ourselves constantly what restores or retains human dignity and the potential for the misuse of power in the practice of medicine.[1] [2] Without this, medical ethics risks becoming another method for creating alienation, moral disengagement and the reification of humanity, with all the dangers that this entails.[3] [4]

[Brendan's Questions: In your experiences as a patient and/or medical caregiver, how "ethically" have medical staff behaved? Can you give some good (or bad) examples?]

4.2 Medical Ethics And The Goals Of Medicine

Some ethicists have described the goal of clinical ethics (also known as 'medical ethics') as the improvement of the quality of patient care by identifying, analysing and attempting to resolve the ethical problems that arise in practice, with ethics integral to the practice of medicine.[5] They earlier expressed the hope that clinical ethics 'will have achieved its rightful place at the interstices of relations between patients who are sick and physicians who profess to be able to heal or comfort them.[6] A review 11 years later led to the conclusion that important improvements had been made in ethics processes, but the goal of improved clinical outcomes had not been achieved.[5] Others reached a similar dispiriting conclusion: that there was no firm evidence that medical ethics education led to ethical behaviour in clinical practice.[7] The reason that medical ethics may not be as successful in its outcomes as in its processes—the latter an extensive body of scholarship and vibrant discourse, as shown in this journal—may be due to the neglect of issues discussed below. 'Medical ethics' covers a range of meanings, and it is timely to consider which of these are useful guides for fostering healing relationships.

[Brendan's Question: This is, of course, a class in medical ethics! What do you think the best approach might be to teaching/learning such material?]

4.3 The Missing Dimensions In Medical Ethics

4.3.1 The need for virtue ethics

The traditional view of medical ethics as a collection of prescriptions and prohibitions, so-called 'code ethics', such as the General Medical Council's guidance Good Medical Practice[8] does not describe how these rules are to be followed, or even clearly articulate why they should be, apart from creating trust. I do not discount the value of trust,[9] but the deeper question of how such codes promote the goals of medicine remains unexplored. Code ethics is incoherent unless placed within a comprehensive theory of human morality and is described as 'the archeological ruins of a doctrine of medical virtue'.[10] Ethics is also depicted as tools to be picked up or discarded depending on the situation at hand. We now have 'medical ethics for dummies'[11] and 'toolkits' for dealing with ethical dilemmas.[12] These may be valuable and useful to busy clinicians, but they convey the notion that ethics is a simple acquisition of technical skills, rather than a more demanding (and life-long) requirement to develop, hone and practise the virtues, to take responsibility as moral agents and to

fully acknowledge the humanity of others. Ethics-as-tools renders moral thought and action extrinsic to individuals' identity.[13] Furthermore, rules and tools simply cannot address core features of clinical ethics—the dynamic relationships between clinicians and patients, the desirable attributes of clinicians or how emotions and reasons are intertwined at the clinical encounter and in clinical–ethical decision making. They ignore the indeterminacy and contingency of life and fail to take into account how institutional culture—'the hidden curriculum'[13]—or the sociopolitical zeitgeist can influence ethical humane practice.[14]

Compassion, in brief, cannot be readily accommodated within a utilitarian, Kantian or even rights-based ethical theory. In contrast, it fits naturally within **neo-Aristotelian virtue ethics [Brendan's note: This is the author's preferred approach. Think about how this differs from its rivals!]**[15] and is gaining support in medical ethics discourse.[16 17] The healing relationship can provide the phenomenological grounding for a normative ethic based on the virtues.[18] Medicine, within this paradigm, represents a social practice with complex cooperative activities that yield goods internal to the practice. These, unlike external goods, enrich the whole community and are achieved by the flowering of the virtues. Personal identity and integrity are founded on a life narrative that we tell ourselves and that we share with others as part of a larger shared tradition.

[Brendan's Question: In your own words, what does it mean to say that "ethical theories" like utilitarianism, Kantian deontology, or rights-based theories are "rules and tools"? How is focusing on the *virtue of compassion* different?]

4.3.2 Moral reasoning and the evasion of emotion

Another oft-stated goal of medical ethics, proficiency at moral reasoning, although important, does not necessarily translate into ethical behaviour.[19] Between the intellectual problem solving in the abstract and facing the concrete reality of persons, there may be a disconnect.[20] Bridging this divide requires a dynamic interplay between detachment and engagement, cognition and emotion and a capacity for self-awareness and honest reflection.[21] Aptitude in moral reasoning may even sometimes correlate with skills in deception.[22] Deliberative decision making can make us less altruistic and compassionate.[23] This leads to another lacuna in much of the discourse and teaching of medical ethics: the emotional dimension.[24] In this context, emotions are often viewed as a hindrance, rather than an aid, to making sound decisions.[25–27] The revival of virtue theory, which incorporates emotions within rational ethical decision making, the inclusion of philosophical emotion theory[28] and neuroscientific knowledge[29] in clinical ethics are thankfully reversing this trend.[30–32]

4.3.3 The neglect of everyday ethics

Medical ethics tends to favour the dramatic or complex 'dilemmas'. While recognising that medical ethics needs a broader canvass,[33] I advocate for a greater focus on the multiple encounters between clinicians and patients (and their families) that form the bulk of medical ethics**. 'Microethics'** is 'not just the terrain of rare spectacular cases involving heroic decisions', but the field of 'day-to-day communication and structured, complex interactions, of subtle gestures and fine nuances of language.'[34] **[Brendan's Question: Can you give an example of what might count as "microethics"?]** Ethics emerges from a process of dialogue involving philosophy, personal values, cultural assumptions, and political and religious beliefs. Within this dialogue, new meanings are created and individuals define who they are. During conversations between doctors and patients, ethical decisions are interwoven with technical decisions in a dynamic iterative process. This perspective shifts the focus from abstract discourse to an exploration of the messy world of intersubjectivity within which moral decisions are made. Clinicians need to connect with the lived experience, the 'lifeworld' of their patients.[35] 'Conversational ethics' values and recognises our social embeddedness and the moral significance of the individual and of reflection.[36 37]

[Brendan's Question: What are some "everyday" ways medical staff can connect with their patients?]

4.3.4 Suffering

It is troubling that patients and laypersons consider the relief of suffering to be one of the primary ends of medicine, yet the medical profession neglects it.[38] This neglect is attributed to the mind-body dichotomy in medical theory and practice. Furthermore, the dichotomy is asymmetrical, with the sciences viewed as 'hard' and the humanities 'soft', creating a 'doubleblinded dichotomous clinical gaze'.[39] We are social, embodied creatures and this can predispose us to suffering. Persons suffer from what they have lost of themselves. Cassell's rich multilayered concept of suffering relates this loss to any facet of personhood: one's life story, plans or hidden dreams, relationships, particular roles or spirituality. Suffering is experienced with the lost capability to do enjoyable or routine activities or to participate in the political realm. 'The body is no longer seen as a friend but, rather, as an untrustworthy friend.[40] The 'latent' role of the clinician is to 'lend strength'—show solidarity—apart from easing the burden of illness with medical or surgical interventions.[41]

4.3.5 Existential neglect

A large empirical study in a hospital setting revealed how the biomedical focus over-rode important existential aspects of the consultation—the personal and human dimensions of the patients' suffering, their feelings and meanings—were systematically excluded. The doctors were courteous, but showed little interest or curiosity about the patients as individuals. Rather, patients were treated as medical objects and often more attention was paid to the computer than to them. The researchers describe this disregard for the patients' humanity as a 'moral offence'.[42] A study in general practice yielded similar findings with the patient's lifeworld often blocked or ignored.[43] Yet creating 'caring conversations' which recognise the patient as a person does not require added time or effort, but greater attentiveness.[44] Patients' narratives describe existential neglect and how this intensifies suffering. Sweeney,[45,] faced with a terminal illness, poignantly relates how fellow doctors 'showed a hesitation to be brave' and lacked a 'willingness to accompany him in the kingdom of the sick. He describes how the transactional aspects of his care were timely and technically impeccable, but that the relational aspects were often sadly lacking, leaving him feeling abandoned. Carel[46] describes a nurse's cold indifference to her distress when discovering that her lung function has undergone a rapid decline. She does not ask for ' feel-good chatting' but wonders if the encounter has to be 'so impersonal, so guarded'— cannot some 'genuine care' be brought in? The lament 'Why am I not treated as a person?' is almost universal. The answer is complex, but suffice to say that we can only claim to be 'doing good medical ethics' by responding well to both medical needs and existential suffering.[47]

[Brendan's Question: In your experience with medicine, have you ever felt like you were NOT "treated like a person?" What happened?]

4.3.6 Compassion and Suffering

Compassion needs to be able to respond to all the dimensions of suffering and to respect the dignity of the person and not slide into pity and condescension. For at the core of the concepts of morality and human dignity is the idea that human beings are not reducible to objects, but are morally valuable and unique.

What do we mean by compassion? Compassion is complex and includes cognitive, affective and motivational elements. It is a capacity that is innate and linked to our evolutionary survival.[48] The two definitions below convey the main elements— noticing, feeling and responding. Also critical is the capacity to tolerate distress (equanimity) such that another person's suffering does not overwhelm and lead to avoidance or denial.

Compassion refers to a deep awareness of the suffering of another coupled with the wish to relieve it…. Although the process of arriving at compassion can be difficult or complex, showing compassion often flows naturally and can be as quick and as easy as a gentle look or a reassuring touch.[49]

Compassion is not simply a feeling state but a complex emotional attitude toward another, characteristically involving imaginative dwelling on the condition of the other person, an active regard for his good, a view of him as a fellow human being, and emotional responses of a certain degree of intensity.[50]

Compassion entails empathic imagination—being able to enter the worldview of another, while retaining the 'necessary distance'—a sense of separateness.[51] This is not an easy task but one that demands practice and courage. I diverge, however, from Nussbaum's stipulation that the sufferer be deserving of our compassion.[28] 'Undeserving' can segue into harsh judgements and uncaring attitudes towards, say, the obese, drug addicts and immigrants 'who shouldn't be here.[52]

[Brendan's Question: How does this account of compassion compare with the "Five Focal Virtues" idea laid out ealier?]

4.4 Some Counterarguments

Compassion receives a mixed reception in the context of medical ethics. On the one hand, it is championed as the basis for medical education,[31] but on the other hand, some authors reject it as an obligatory element of ethical clinical practice.[53] Compassion is like a flickering flame: a number of factors, explored in depth elsewhere, can extinguish it.[47] Although we need virtuous organisations for its flourishing, that does not mean morality is entirely socially situated or the virtues are fictional.[54] Some argue that etiquette may suffice for good medical practice.[53 55] Certainly, adherence to etiquette could ensure courtesy and may even foster the habituation of some virtues, but will fail to address existential issues, or give guidance for responding to distress.[41 56] Contrary to broadly-held belief, the enactment of compassion is rewarding, not depleting. 'Compassion fatigue stems from a lack of self-compassion and unbalanced, unreflective emotional empathy (with which it is often confused), not compassion.[57] There is, Aristotle would argue, a 'golden mean.[58] Compassion alone is insufficient for healing and needs to be unified with the other virtues, particularly discernment, temperance and phronesis or practical wisdom.[58]

4.5 Conclusion

Compassion is a central and necessary element of good medical care and integral to good medical ethics. Compassion is both humble and powerful. It is subversive because it eschews hierarchy and privilege and runs counter to the libertarian, market-orientated industrialised medicine of today. It is embedded in a framework of reciprocity and shared meanings and is underpinned by an ethic of virtue. It demands both the recognition of our common humanity and the honouring of the individual narrative. Compassion views humans as interdependent and vulnerable, with autonomy textured by our milieu and relationships. It responds to, but does not generalise suffering. Above all, it connects with our better selves and what it means to be human.

Competing interests None.

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5 EMPATHY IS AN OVERRATED SKILL WHEN DISPENSING MEDICAL CARE (BY KARIN JONGSMA AND VERENA KLAR)[6]

Over the past few decades, empathy – the ability to take on the perspective, or 'feel' the emotions, of another person – has been touted as a key clinical skill, and a cornerstone of the doctor-patient relationship. Communication with and trust in the doctor hinges on this quality, research suggests, right along with patient satisfaction and clinical outcome of the treatment itself. Many physicians are now trained to be empathetic, but still struggle with showing empathy all day, every day. After all, physicians are only human, prone to exhaustion and stress, and simply not empathetic *all* the time. The proposed solution is simple: fake it till you make it; even if you don't feel empathetic with your patient, you should at least give the impression that you are. But why do we deem a treatment incomplete without it, when empathy is neither easily employable nor a miracle cure?

It might be time to reconsider the importance of empathy as an essential physician skill. Consider its fierce requirements: cognitively, the empathiser must put him or herself in the patient's shoes and then go further to *feel with* that patient, such that emotional boundaries dissolve.

We've long assumed that the empathising doctor is the better doctor, but both aspects of empathy – the cognitive and the emotional – can malfunction. From the cognitive end, our ability to walk in someone else's shoes is biased and not neutral; we walk easier in shoes that fit us. We are more inclined to feel empathy for attractive people and for those who look like us or share our ethnic or national background. And from the emotional end, we underestimate the influence of affective states such as anxiety or depression on other people's behaviour when we are not effectively aroused ourselves, leaving the door open for undertreatment of issues such as pain. And studies have indicated that the act of '*feeling with*' is exhausting; feeling another's pain could be a source of distress and depression for the empathiser.

Absence of empathy, meanwhile, could be a boon. Surgeons, for example, commonly conceal the personal features of their patients and look only at the surgical site, to boost their finesse. In psychotherapy, empathy can be counterproductive. Patients suffering from mental disorders including low self-esteem tend to seek self-verification instead of self-enhancement; empathetic reinforcement of their negative self-concept could be damaging in the extreme.

On top of all this, medical care is an active feat, while empathy, though motivating, does not in and of itself require action. Indeed, empathetic arousal is not the only force that can motivate one to care: a sense of justice and allegiance to duty can work as well. We want our doctors to acknowledge our needs and act accordingly, yet we don't actually need them to mirror our pain.

In fact, this final requirement is most closely related not to empathy but to *compassion* – defined among emotion researchers as the feeling that arises when you are confronted with another's suffering, including the desire to help. This non-empathetic compassion – a more distanced love and kindness and concern for others – might act as a bridge between recognising the other's feelings and providing care without the detriments of empathy. Since compassion does not require identification with the patient, it can help in performing good care as a professional duty, building trust, and treating someone according to his or her needs, while avoiding cognitive biases and empathetic distress.

[6] Karin Jongsma and Verena Klar, "Empathy Is an Overrated Skill When Dispensing Medical Care | Aeon Ideas," *Aeon*, December 15, 2016, https://aeon.co/ideas/empathy-is-an-overrated-skill-when-dispensing-medical-care.

Empathy still matters in healthcare settings that don't require action: self-help forums and family-support coordinators can be guided by empathy. And precisely because empathy is biased, physicians should be trained to critically reflect upon their empathy gaps rather than be told to fake it.

But when it comes to critical care, physicians should listen carefully and pay attention to what patients say and how they act. That is how they can best determine the appropriate *action* – their professional obligation on the patient's behalf.

Brendan's Questions

1. **In your own words, how would you describe the difference between "empathy" and "compassion"? Which do the authors think is more valuable?**
2. **Do you agree with the claim that empathy is overrated? Why or why not?**

6 READING: HOW FLORENCE NIGHTINGALE PAVED THE WAY FOR THE HEROIC WORK OF NURSES TODAY (BY SUYIN HAYNES)[7]

English nursing pioneer, healthcare reformer and Crimean War heroine Florence Nightingale (1820 - 1910).

Brendan's Reading Questions:

1. **Nightingale is often credited as the "founder" of modern nursing. Why/how did she help turn nursing from a (pretty low status) "job" into a respected "profession"?**
2. **To what extent does Nightingale exhibit the Five Focal Virtues?**
3. **What can modern medical professionals learn from Nightingale (especially when it comes to value)? What would it mean to "strive to be more like Florence Nightingale?"**
4. **How has nursing (and what is expected/required) of nurses changed from Nightingale's time to our own?**
5. **What were Nightingale's ethical strengths? Her weaknesses?**

When Greta Westwood was 4 years old, she read a children's book about Victorian nurse Florence Nightingale. Decades later, she still remembers being transfixed by the enduring image of the "Lady with the Lamp." Westwood herself would go on to a distinguished nursing career of her own, starting out as a student orthopedic nurse in 1978. "From day one of putting the uniform on, I've never looked back," she recalls.

[7] Susan Haynes, "How Florence Nightingale Paved the Way for the Heroic Work of Nurses Today," *Time*, May 12, 2020, https://time.com/5835150/florence-nightingale-legacy-nurses/.

Although she left Britain's National Health Service in 2017 after nearly 40 years, Westwood has recently returned to her local hospital in Portsmouth, in the south of England, to help with the U.K.'s public health efforts in the coronavirus crisis. Westwood, who spoke to TIME on a busy Monday morning from the hospital, has been running psychological support sessions for nurses and midwives assisting patients with COVID-19 for the past six weeks.

That early image of Florence Nightingale, tending to wounded soldiers in the darkness with her lamp, has endured for so many nurses, for so many years, and takes on renewed significance as May 12 marks the 200th anniversary of Nightingale's birth. It also marks International Nurses' Day, commemorated in Nightingale's honor. With nurses around the world on the front lines of a global pandemic, it's a poignant time to reflect on how Nightingale's legacy laid the groundwork for their heroic work in hospitals today. "It's the trailblazing element I like about her," says Westwood, who is also the CEO of the Florence Nightingale Foundation. "She never took no for an answer—anything was possible."

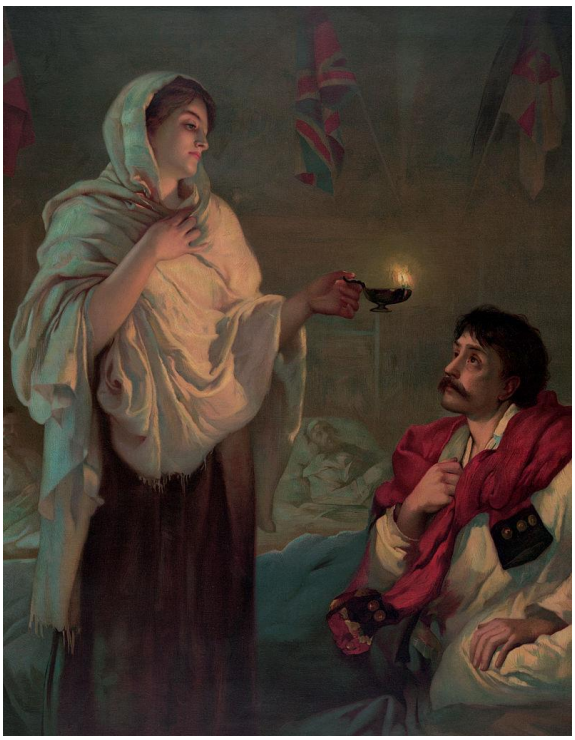

Figure 2Print published 1891. From the painting by Henrietta Rae (Mrs. Normand). Photo by VCG Wilson—Corbis via Getty Images

Nightingale was born on May 12, 1820, to a wealthy aristocratic family in Italy, and grew up in England. As a teenager, she believed that she had heard a call from God encouraging her to help the sick and poor and felt a strong desire to become a nurse—although the profession was not seen as a respectable job at the time. Victorian social conventions also meant that women were generally expected to stay at home and run household affairs, not pursue careers; Nightingale turned down multiple marriage proposals because she felt it would interfere with her duty of caring for others. Her ambitions were particularly controversial given her upper-class background. But despite her family's disapproval, she educated herself in arts and science and eventually gained some nursing experience at a Lutheran-run institution for the poor in Germany.

In March 1854, Britain entered the Crimean War, fighting in an alliance against Russia. Newspaper reports detailed the devastating state of hospitals that cared for the wounded, and, in the face of public outcry at home, War Minister Sidney Herbert appointed Nightingale to lead a contingent of 38 volunteer nurses to a military hospital in Scutari, in modern-day Turkey, in the November of that year, to help wounded soldiers returning from the front lines.

Nightingale's team was immediately confronted by nightmarish conditions. More soldiers were dying of diseases such as typhus, typhoid, cholera and dysentery than from battle wounds, and the hospital wards were overcrowded with rat and lice infestations.

"What greeted her there must have been horrendous in terms of the squalor," says David Green, director of the Florence Nightingale Museum in London. "But she stayed until the end, and made sure she looked after the common soldier, not just the officer."

Nightingale's compassion set her apart from others, says Green, and she gained her famous moniker for checking in on her patients by lamplight, often writing letters to loved ones at home on their behalf. At that time, the army didn't always inform families when soldiers were killed, but Nightingale felt a duty to do so.

That sense of duty to patient and family has been on full display during the COVID-19 crisis, as nurses champion the need to be with patients until the very end, and have campaigned for iPads so relatives can communicate with loved ones. "That is so Nightingale, and that compassion really carries home," says Green.

Nightingale's time at Scutari prompted several innovations that she would develop in the later years of her life. Although the male doctors at the institution saw Nightingale's suggestions as criticisms, she remained steadfast, taking several measures to improve sanitation and hygiene at the hospital, including washing the linens and towels, purchasing necessary kitchen supplies, and emphasizing hand-washing with soap and water, which was not widely practiced at the time. However, through 1855, the mortality rate at the hospital continued to rise, as Nightingale mistakenly believed that nutrition and supply problems were the main cause of the issue, rather than the sanitation problem. A Sanitary Commission found that the hospital was built on a sewer, meaning that the water supply was contaminated and helping to increase the spread of disease.

Nightingale returned to Britain in 1856, having learned from the experience. In the years that followed, she championed sanitary health—and cemented her status as a national hero.

For the next 50 years of her life, she prioritized the establishment of nursing as a respected profession. Her 1859 book *Notes on Nursing* is still regarded today as a pioneering text, was written in simple language intended for women nursing in the home to understand. One of her first tasks after returning from the war was to set up a training school for nurses in 1860, the first to exist in the world, which still runs today. "If you speak to any nurse about nursing, everybody comes to work to do their best for their patient. Through all those years even when she came back from Crimea, that was her purpose in life," says Westwood.

Despite battling depression and being intermittently bedridden from 1857, Nightingale wrote thousands of letters campaigning for public health and workhouse reform, and used her influence to network with Queen Victoria and prominent politicians. It was also from her experience in Crimea that she learned about efficient hospital planning and design. In correspondence with other hospitals around the world, from Sydney to New York City, she shared her knowledge and the resources of the "Nightingale Nurses" that had been trained through her school.

Significantly, Nightingale backed up her campaigns with evidence, statistics and data visualizations that were easy to understand, using diagrams to show the effects of infection and mortality rates in the Crimean War. "She was the pioneer of the first pie chart," says Westwood, comparing the public's need for data during Nightingale's time and our own. "When the Prime Minister or Chief Medical Officer do their briefings on the coronavirus today, we now see that data published as infographics. Nightingale got it that people wouldn't understand the data unless she made it explicit and unquestionable."

While her legacy has endured two centuries later, Nightingale's bicentennial comes at a crucial time for nurses on the front lines, and a moment of financial challenge for the museum dedicated to her memory, due to its current closure. "It's ironic that many of the field hospitals [in the U.K.] have taken her name," says Green of the Florence Nightingale Museum, which houses almost 3,000 artifacts dedicated to her legacy, "but the thing that is always around to remind everyone of her might not be."

For the Florence Nightingale Foundation, which was set up in 1934 to remember her legacy and actively supports nurses and midwives through scholarship programs, their usual commemoration of Nightingale's birthday is adapting to the current lockdown situation. Supported by *The Crown* actor Helena Bonham Carter, whose great-great-grandmother Joanna was Nightingale's aunt, the Foundation is launching the Florence Nightingale White Rose Appeal, through which people worldwide can buy an e-white rose to help support nurses currently working on the front lines. Each rose bought will form part of an actual floral display at London's Westminster Abbey once lockdown ends, to celebrate the contribution of nurses and midwives everywhere.

It's quite a different bicentenary compared to what Westwood had envisaged, but the woman at its heart would not have shied away from the difficulty.

"Celebrations is a weird word at this time, because it is tinged with sadness—so many nurses have died, and we mustn't forget that," Westwood says. "But Florence would be so proud of what nurses have managed to achieve during this pandemic."

7 COURAGE AND COMPASSION: VIRTUES IN CARING FOR SO-CALLED "DIFFICULT" PATIENTS (BY MICHAEL HAWKING ET AL).[8]

Abstract. What, if anything, can medical ethics offer to assist in the care of the "difficult" patient? We begin with a discussion of virtue theory and its application to medical ethics. We conceptualize the "difficult" patient as an example of a "moral stress test" that especially challenges the physician's character, requiring the good physician to display the virtues of courage and compassion. We then consider two clinical vignettes to flesh out how these virtues might come into play in the care of "difficult" patients, and we conclude with a brief proposal for how medical educators might cultivate these essential character traits in physicians-in-training.

Virtue is what makes its possessor good, and his work good likewise.

Aristotle [1]

7.1 INTRODUCTION

In his 1978 article, "Taking Care of the Hateful Patient" [2], James E. Groves wrote about "those [patients] whom most physicians dread" [3]—patients who, as others have noted, seem to display "behavioral or emotional aspects" such as "psychiatric disorders, personality disorders, and subclinical behavior traits" that, while not necessarily related to their primary medical condition, nonetheless complicate their care [4]. What, if anything, can medical ethics offer to assist in the care of such patients? Modern health care ethics frameworks—typically utilizing deontological or consequentialist reasoning—respectively focus on rules and principles or pursue a decision that's likely to bring about the greatest good for the greatest number. In contrast, virtue ethics calls our attention to a physician's character.

7.2 VIRTUE ETHICS AND MEDICINE

Edmund Pellegrino [5] writes that virtue ethics is "the oldest philosophical foundation for moral conduct" [6]. It traces its roots back to Plato and Aristotle, was reinvigorated and bolstered by the likes of Averroes and Thomas Aquinas in the Middle Ages, and fell out of favor around the time of the Enlightenment [5]. In the 1980s, G. E. M. Anscombe's essay, "Modern Moral Philosophy," and Alasdair MacIntyre's *After Virtue* brought the tradition back into conversation with modernity, and Pellegrino and others have brought the tradition's insights to bear on clinical practice [5, 7-11].

Rather than focusing on rights, duties, or utility maximization, virtue ethics focuses on the cultivation of certain traits—virtues—that, taken together, dispose an individual to act justly in a particular situation [10]. James Rachels, drawing on Aristotle, defines a virtue as a "trait of character, manifested in habitual action, that is good for a person to have" [12]. **[Brendan's Note: This is one of the more common modern definitions of virtue.]** These traits, which are developed through practice, are necessary for an individual to flourish. "Flourishing" has come to be the preferred translation of Aristotle's concept of *eudaimonia*, which

[8] Michael Hawking, Farr A. Curlin, and John D. Yoon, "Courage and Compassion: Virtues in Caring for So-Called 'Difficult' Patients," *AMA Journal of Ethics* 19, no. 4 (April 1, 2017): 357–63, https://doi.org/10.1001/journalofethics.2017.19.4.medu2-1704.

means something like "living well" or "faring well" [13]. It conveys an active state of genuine well-being and fulfillment.

To give a concrete example of a virtue that will be familiar to anyone in medicine, consider the virtue of temperance. A temperate person exhibits appropriate self-control or restraint. Aristotle describes temperance as a mean between two extremes [13]—in the case of eating, an extreme lack of temperance can lead to morbid obesity and its excess to anorexia. Intemperance is a hallmark of many of our patients, particularly among those with type 2 diabetes, alcoholism, or cigarette addiction. Clinicians know all too well the importance of temperance because they see the results for human beings who lack it—whether it be amputations and dialysis for the diabetic patient; cirrhosis, varices, and coagulopathy for the alcoholic patient; or chronic obstructive pulmonary disease and lung cancer for the lifelong smoker. In all of these cases, intemperance inhibits a person's ability to flourish. These character traits do, of course, interact with social, cultural, and genetic factors in impacting an individual's health, but a more thorough exploration of these factors is outside the scope of this paper.

How does one come to be virtuous? Consider the case of a prediabetic patient who, through conversations with his doctor and reading on his own, realizes that he is teetering on the edge of a serious medical condition and resolves to change his lifestyle. He might begin by foregoing his usual morning donut. He will probably struggle at first, but after choosing a healthier option several days in a row, choosing will become easier. Next, he may give up his afternoon soda and late-night snacks. As he chooses day-in and day-out to resist his appetites for tasty, high-carb foods, he will grow in temperance to the point that refusing unhealthy foods becomes a habit. Thus, by practicing temperance with respect to tasty but unhealthy foods, the patient will have redirected his trajectory away from diabetes and towards better long-term health.

Virtues are thus habits of character cultivated through practice that result in the actions essential for an individual to flourish. What then, does this mean for practitioners of medicine? Pellegrino wrote that the medical virtues "focus primarily on those traits necessary to do the work of medicine well. The good that medicine seeks … is ultimately the preservation, promotion and restoration of health" [14]. Pellegrino lists what he takes to be six essential virtues for the clinician: *fidelity, honesty, compassion, effacement of self-interest, courage, and justice* [5]. Defining, defending, or expanding this list is beyond the scope of this essay, but to illustrate the importance of medical virtues, we focus on two of these six—namely courage, or the strength of character that enables one to do what is appropriate or necessary in the face of fear or aversion [1], and compassion, or what Beauchamp and Childress describe as "an active regard for another's welfare with an imaginative awareness and emotional response of deep sympathy, tenderness and discomfort at another's misfortune or suffering" [15]. As we will see, courage and compassion are especially essential in the care of the "difficult" patient.

[Brendan's Question: What do you think of "temperance" as a virtue that we can get better at with practice/effort? Can you give examples from your own life/experience?]

7.3 THE "DIFFICULT" PATIENT

As noted above, some have drawn attention to those patients who make "repeated visits without apparent medical benefit, patients who do not seem to want to get well, patients who engage in power struggles, and patients who focus on issues seemingly unrelated to medical care" [4]. Groves [2] attempts to categorize "difficult" patients into four types: *clingers* (needy patients who evoke aversion and need clear boundaries), *demanders*(entitled patients who use intimidation, devaluation, and guilt to get what they want), *help-rejecters* (pessimistic, needy, nothing-works patients who evoke self-doubt), and *self-destructive deniers* (who display self-destructive behavior, ignore recommendations, and evoke strong negative feelings). **[Brendan's Question: Have you have ever met a patient in one of these categories? Have you ever**

been this way yourself?] Any student or clinician who has been in practice can recognize, and likely conjure particular memories of, patients who fit these categories. Caring for "difficult" patients is an inescapable part of medicine, and thus learning to care well for these patients is an essential part of physician formation. The examples of *demanders* and *self-destructive deniers* particularly help to illustrate the importance of courage and compassion in clinical practice.

Demanders. Imagine walking into an office visit with a patient who suffers from chronic low back pain and narcotic dependence. This patient is well-known to you; on your last visit you had discussed weaning the narcotics prescribed by his previous physician. "Doc, I need a refill! I ran out and the pain is unbearable!" the patient exclaims without any evidence of distress. You check the state's database and see that he filled his month's prescription ten days ago. You reiterate the need to transition off narcotics and the patient reacts with outrage: "Don't you care about my pain? It's terrible! You're an awful doctor."

To remain firm in one's refusal of narcotics for this patient requires a certain degree of courage. It would certainly be *easier* to refill the prescription and send him on his way. That would avoid the discomfort the physician would likely experience after refusing the patient's request, as patients with substance use disorders can escalate these situations through coercive language or threatening to file complaints. Nevertheless, the good physician will stay the course and refuse demands for treatments that the clinician believes are not indicated, even when doing so means withstanding hostility from the patient. At the same time, a good clinician will resist the temptation to resent such patients and write them off as manipulative drug seekers. Here, the virtue of compassion enables a clinician to suffer with a patient, imaginatively calling to mind and lamenting that patient's experience of pain and addiction. Compassion promotes empathy rather than resentment and thus facilitates a healthier patient-clinician relationship.

Self-destructive deniers. Now imagine a patient whom you are seeing in the ICU. She is immunosuppressed and very sick with what will likely be a terminal pneumonia; furthermore, she is intermittently refusing to take the antibiotics you have prescribed for her while also refusing to consider home hospice. You discover that her pneumonia developed at least in part because she was not taking her prophylactic medications at home. Repeated goals-of-care conversations have only resulted in the patient and her family growing increasingly hostile to the care team. When a nurse pages you yet again to tell you that the patient is refusing today's dose, you might feel exasperation. You might dread another conversation with the patient, and it would be easy to simply ask the nurse to skip the dose.

The patient's health, however, hangs in the balance. Here, courage can equip a clinician to try yet again to form an alliance with a patient and persuade her to cooperate in her care—despite fearing that these efforts will fail while only consuming limited time and energy. Furthermore, compassion can enable a clinician to imagine and regret the helplessness and anxiety the patient might experience and to remain in solidarity with her simply because she is sick—notwithstanding how challenging it is to care for her. Compassion can evoke efforts to understand the roots of a patient's noncompliance and resistance, and courage can sustain a clinician in those efforts when doing so is difficult. Together, these virtues help to overcome conflict in the patient-clinician relationship that otherwise frustrates the possibility of healing.

7.4 Courage and Compassion as Virtues Necessary for Medical Practice

Martha Nussbaum and Amartya Sen discuss virtues as traits needed to overcome the challenges of life [16]. So understood, the medical virtues are traits needed to overcome challenges in clinical practice. So-called "difficult" patients test clinicians' characters, requiring and calling forth virtues such as courage and compassion. Susan D. McCammon and Howard Brody note that "the ultimate development of virtuous character" is exemplified when "such actions are habitual and are defaulted to even in times of significant

stress" [17]. Without such virtues, a clinician might respond to a so-called "difficult" patient with aversion, pacification, and resentment, and could thereby fail to act in ways that facilitate that patient's healing. As Thomas Percival initially noted and Jack L. Coulehan has reiterated, physicians in their care of patients must unite "tenderness with steadiness" [18, 19].

A number of authors have argued that medical schools should make concerted efforts to instill virtues in their students [5, 7-9, 11, 17, 19, 20-21]. Such efforts will in no small part involve positive role modeling by virtuous faculty, and, as Kyle E. Karches and Daniel P. Sulmasy note, such modeling will necessarily resemble "the way in which a master musician teaches a student"—a kind of longitudinal "apprenticeship" with an exemplar "capable of recognizing and cultivating excellent performance" [22]. Educators can model what virtuous behavior looks like for their students and trainees. Virtuous exemplars can thereby help counteract the "hidden curriculum" of medical training, through which corrosive values and behaviors are so often displayed by resident and attending clinicians and thereby habituated in medical students [8, 23]. Some have argued for an educational model of formation in which lives of service are created and sustained in intentional learning communities that link the "lived experiences of mentors and learners with an interdisciplinary set of didactic materials" [20]. Schools that have adopted a similar model of moral formation tend to emphasize the use of narrative, the creation of a rich community of learners, and intentional reflective processes in a longitudinal curriculum that fosters an apprenticeship model of clinical education [20, 21, 24].

At all stages of medical education, clinicians can be trained to practice with courage and compassion. Repeated practice allows these traits to settle in more deeply as habits of character that equip clinicians to act in ways that facilitate their patients' healing—even when patients' behavior makes the clinicians' task more difficult. So-called "difficult" patients can push physicians to their limits, but, as was illustrated in the cases above, deeply ingrained courage and compassion enable a clinician to push through the difficulties to pursue patients' health even in the most challenging of circumstances.

[Brendan's Question: How do you think future medical professionals should/could be taught the "virtues" of good patient care?]

7.5 REFERENCES

Available at 10.1001/journalofethics.2017.19.4.medu2-1704.

8 CASE STUDY: MEDICAL BRAIN DRAIN (ETHICS BOWL)

From the *Ethics Bowl: National Cases (2020-21)* by the Parr Center for Ethics. https://nhseb.unc.edu/case-archive/

Maryam just finished her medical training in Nigeria. She dreams of using her degree to gain citizenship in the United States . This hope was, in fact, the main reason she went to medical school in the first place. She knows that the U.S., like other countries, is facing a healthcare worker deficit and prioritizes health workers in their admissions policies. If she can leverage her degree for citizenship, she can ensure a life of comfort and stability for herself as well as her family.

Yusuf is one of countless Nigerian citizens in desperate need of medical care. While healthcare worker shortages are common, the need in low-income countries like Nigeria is particularly dire. Whereas the U.S. has 2.6 health workers per 1,000 citizens, Nigeria has 0.4.1 This is not just because Nigeria cannot train enough health workers to meet their needs, but because places like the U.S. continue offering citizenship to Nigerians with medical degrees. According to a recent estimate, there are 8,000 doctors from Nigeria working

in the U.S., whereas there are only 35,000 Nigerian doctors working in Nigeria.2 Because of this shortage , Yusuf never receives the care that he needs.

This is known as the medical brain drain. It involves high rates of medical workers migrating from low- to high- income countries . And though there is disagreement on the empirical effects of the brain drain- including whether remittances adequately compensate, whether people pursue medical training because they can migrate, and whether return migration occurs enough to mitigate the problem-there is reason to think that the brain drain undermines the ability of low-income countries to meet the healthcare needs of their already underserved citizens. In other words, the cumulative effect of high-income countries and medical workers from low-income countries pursuing their interests through migration policies is that the globally least advantaged receive even less adequate healthcare. Such people likely die prematurely and live lives with more pain and less flourishing .

Critics of the brain drain allege that high-income countries are taking advantage of their bargaining power.

Because they can offer medical workers salaries that are exorbitantly higher than those offered in low-income countries, they are able to secure a large number of medical workers without having to pay for their education. Critics also argue that emigrating medical workers are taking advantage of their communities. From birth and through their medical training, scarce state resources were used to help shape their in-demand skills. After receiving this education and training they immigrate to greener pastures and larger paychecks, leaving behind an already poor-and now even poorer- community .

However, their opponents note that none of the actions undertaken are at odds with everyday morality. High-income countries receive many more petitions for citizenship than they can, or will, accept. They simply use domestic labor needs as one way to decide between would-be migrants. Moreover, people like Maryan are just seeking to escape poverty and instability. And the rights to choose where to live, where to work, and what work we want to do are among the most important rights that we have.

8.1 DISCUSSION QUESTIONS

1. Does Maryan do anything wrong by choosing to leave Nigeria for the United States? What kinds of duties, if any, does she have to her fellow Nigerians and to the Nigerian government?
2. Is it unjust for the United States to offer residency or citizenship to people like Maryan over people like Yusuf? If so, what kind of immigration policies would be just?
3. If the brain drain undermines justice in healthcare in Nigeria, is it permissible for Nigeria to place restrictions on emigration, keeping people like Maryan there for several years upon graduation?