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FORUM

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Abstract

Tom L. Beauchamp and James F. Childress’ (B&C) book *Principles of Biomedical Ethics* is well-known for its four principles approach to biomedical ethics. However, the authors also emphasize the importance of the virtues of health care personnel. After a short overview of virtue ethics, the five “focal virtues” described by B&C are discussed and applied to a chronic pain example. The question of how virtues are learned in the health care setting is addressed, and it is argued that virtues such as the ones defended by B&C are acquired when health care personnel are socialized in an environment dedicated to the continuous upholding of practices that aim at the telos of medicine. Viewed from this perspective, professional isolation can be considered to be dangerous, the upholding of medical professionalism throughout a whole career largely presupposing the existence of a community where virtues relevant to the practice of medicine are embodied and kept alive. The concept of professional socialization is important in that respect. Finally, some potential general implications of this view for continuing professional development are proposed.

Keywords

character; ethics; professionalism; socialization; virtues
Introduction

Almost four decades ago, Tom L. Beauchamp and James F. Childress (B&C) published the book *Principles of Biomedical Ethics* and thereby “unleashed” the four principles of respect for autonomy, non-maleficence, beneficence, and justice on the newly emerging field of biomedical ethics. The seventh edition of the book was published in 2013. The principles advocated by B&C have attained almost canonical status in the field of bioethics, so much so that when, for instance, a Swedish Government Official Report about end-of-life care mentioned them as “the most well-known and generally well-recognised principles,” the authors did not feel the need to reference the claim. This illustrates how deeply the *four-principles approach* to biomedical ethics, now commonly designated *principlism*, has permeated the field. However, it does not seem to be as well-known that B&C devote a whole chapter of their book to moral *virtues*, stating that “although principles and virtues are different and taught differently, virtues are no less important in the moral life.”

It has been claimed that “the current focus on moneymaking and the seductions of financial rewards have changed the climate of US medical practice at the expense of professional altruism and the moral commitment to patients.” In a paper in *Journal of Continuing Education in the Health Professions*, it was recently argued that virtues are necessary for upholding medical professionalism in face of the risk of medicine turning into a business. In the present paper, the importance of virtues in health care will be discussed, including how they might be acquired. The important question of the development of cynicism in medical students as an antecedent to lapses in virtues later in a medical professional’s life will not be addressed in the present paper.

Because speaking of virtues may seem almost esoteric to some, I will begin by first giving a very short overview of virtue ethics. Second, I will discuss the “focal virtues” described by B&C, applying them to a chronic pain example. Third, I will ask how virtues are learned in the health care setting, arguing that virtues such as the ones defended by B&C are acquired when individuals are socialized in an environment dedicated to the continuous upholding of practices that aim at a deeper *telos* then moneymaking. Hence, professional isolation will be shown to be a danger to professionalism, the latter presupposing the existence of a community where virtues relevant to the practice of medicine are taught, exemplified, and kept alive. Finally, I
will conclude by drawing some potential general implications for continuing professional development (CPD) educators.

The importance of virtues

To some, speaking of virtues in the context of an evidence-based health care may seem strange indeed. However, virtue ethics is simply one of three major approaches in normative ethics, the other two being rule-based ethics (e.g., Kantian deontology) and consequentialism (e.g., utilitarianism). After being eclipsed during the 19th and first half of the 20th century, virtue ethics has forcefully re-emerged in ethical theory.

Theologian and virtue ethicist James Wm. McClendon Jr. was critical of what he called "decisionism", i.e., the belief that "morality consists in decision making." Indeed, virtue ethicists looks beyond decisions and even the deeds themselves to the characteristics of the agent. Simply put, virtue ethics can be viewed as subject-focused, i.e., the focus is on the character of the agent ("who is it that is acting, and what kind of person is she?") and not primarily on the actions themselves. In contrast, the two other major strands of normative ethics are action-focused, i.e. they focus on what agents actually do ("what is the right thing to do?").

Focusing exclusively on actions and thereby disregarding the intentions of a moral agent is arguably problematic because, as B&C express it,

> We care morally about people’s motives, and we care especially about their characteristic motives and dispositions. That is, we care about the motivational structures embedded in their character. Persons who are motivated through impartial sympathy and personal affection, for example, meet our moral approval, whereas others who act similarly, but are motivated merely by personal ambition, do not.\(^2\)\(^{(p31, emphasis added)}\)

Although B&C’ book has a strong "decisionistic" and rule-based flavour in that it emphasizes four principles (with only a loose distinction being drawn between rules and principles\(^2\)(p14)), it also has a strong virtue ethics side, the authors stating that “virtues are no less important in the moral life”\(^2\)(p30). We now turn to the five focal virtues discussed by B&C.
Compassion

According to B&C, empathy alone may not be “sufficient for humanizing medicine”\(^2\). What is needed is compassion, defined as a combination of “an attitude of active regard for another’s welfare with an imaginative awareness and emotional response of sympathy, tenderness, and discomfort at another’s misfortune or suffering”\(^2\). The importance of compassion has recently been emphasized in the context of so-called compassion-focused therapy.\(^1\) Noticing the negative effects of shame (making an important distinction between feelings of shame and guilt) and the positive effects of compassion as an antidote, Gilbert has proposed a compassion-centred model that transcends mere sympathy (from *syn*, together, and *pathos*, suffering, in Greek) and that describes 12 compassion-related competencies, one of them being “the ability to use reasoning, wisdom and acquired knowledge/skills”. This view of compassion extending beyond mere feelings is arguably important because, as B&C remind us, compassion “may cloud judgment and preclude rational and effective responses”. When one for instance meets a patient with severe unspecific chronic low back pain who has (as her referring physician put it) “tried everything” except opioids, mere sympathy (i.e., suffering with) may compel the pain physician to “do something” (as patients often put it). If the all-important virtue of compassion is not complemented by e.g. discernment (see below), this “something” may turn out to be far from evidence-based, e.g. the prescription of opioids.

But how does one maintain and even grow in true compassion without at the same time losing judgement and rationality? This is arguably a real challenge for health care personnel, the risk of cynicism being ever-present as a protective strategy against simplistic sympathy. As will be discussed below, growing in compassion should not be seen as an individual feat achieved by sheer force of will. Virtues grow when the individual is immersed in a group of people who celebrate the virtue in question, i.e. when the individual is part of a team where the virtue of compassion is valued as an important driving force towards the *telos* of healthcare – the true wellbeing of the patient. In such an environment, strong compassion need not entail irrationality or dangerous clouding of judgement.

Discernment

The virtue of discernment is sometimes associated with the Aristotelian concept of *phronesis*, perhaps best translated by *practical wisdom*. As a form of knowledge in its own right,
alongside *episteme* (know that) and *techne* (know how),\(^{12}\) *phronesis* has to do with the capacity to choose the wisest course of action in a difficult situation “while keeping emotions within proper bounds”\(^{2}(p39)\). Hence, combining compassion and discernment is arguably an ideal that is as desirable as it is difficult to achieve. In health care, the combination of mere theoretical knowledge and technical skills is not enough. Equipped with both *episteme* and *techne*, the doctor has to choose a wise course of action amid uncertainty and perhaps even confusion. In other words, the doctor needs discernment, i.e. the capacity to wisely use *episteme* and *techne* in a concrete situation without at the same time losing compassion. When facing a patient with chronic pain, and to return to the above-mentioned problem concerning the prescription of opioids, the doctor has to be wise enough to discern what is truly in the patient’s best interest. While it may feel good to “help” the patient with an opioid prescription (at least, you’re *doing* something!), it may not be the wisest or even the most compassionate thing to do.

**Trustworthiness**

Among the five virtues discussed here, trustworthiness seems to be the one that is most dependent on its social recognition in order to “work” – you are deemed trustworthy by *someone else*. You can be both compassionate and discerning (see above), as well as integer and conscientious (see below), without anyone around you noticing. But if you are not publicly known as worthy of trust, although you actually are, then your trustworthiness is edgeless. If trust is understood as a relational concept that “involves the ability to take for granted the motivations and behaviour of others in social interaction”,\(^{13}\) this is perhaps to be expected. Hence, the virtue of trustworthiness seems to presuppose the existence of some kind of community in which the virtue is not only nurtured but also recognized.

The trust of others is earned over time as part of being member of a team – for instance, a medical practice, a clinic, or a hospital. Of course, competence (i.e., *episteme*, *techne*, and *phronesis*) is all-important for professional trust to develop (who would trust a health professional that is *incompetent*?), but there seems to be something more about trustworthiness than mere competence. This “something” that makes a health care professional trustworthy has arguably to do with dependability and commitment to a *telos* that is larger than the self, i.e., people around the trustworthy health care professional take for granted (i.e., they trust) that her actions are motivated first and foremost by a genuine concern for the welfare of the individual patient. A trustworthy professional does not shy away from tasks to be done, but above all
people in the team have learnt that one can rely on her. Such dependability has to do with the character of the individual – it is a virtue.

**Integrity**

B&C distinguish between two senses of integrity: “The first is a coherent integration of aspects of the self – emotions, aspirations, knowledge, and the like – so that each complements and does not frustrate the others. The second is the character trait of being faithful to moral values and standing up in their defense when necessary.” In the second sense, integrity has to do with courage, and in this context it arguably includes holding on to what one is convinced of is in the patient’s best interest, even when she is not happy about it. To return to our patient with chronic back pain, not prescribing opioids may be associated with a lot of pressure. Depending on how the health care system is organized, there might even be financial incentives involved, i.e., there might be a strong need of a substantial dose of integrity in order for the physician not to sacrifice her professionalism. B&C also mention the possibility of a conflict between moral integrity and professional integrity, i.e, if personal moral convictions conflict with professional duties. Such dilemmas can be difficult to solve, and B&C stress the importance of other virtues such as humility, patience, and tolerance when dealing with such issues.

**Conscientiousness**

Conscience, according to B&C, “is a form of self-reflection about whether one’s acts are obligatory or prohibited, right or wrong, good or bad, virtuous or vicious”. One does not need to subscribe to a Freudian view of the psyche (the angry *superego* overlooking the *ego* as the latter tries to deal with the subconscious drives of the *id*) to recognize that much of our doing and thinking is controlled by a moral imperative of some sort. For physicians such as myself, it may e.g. the World Medical Association (WMA) pledge that we proclaimed when I graduated from medical school. Importantly, despite the frequent use of the pronoun “I”, the WMA pledge is not only about private morality; the pledge attaches the individual to a *tradition* (the “noble traditions of the medical profession”). Hence, being a physician, according to the WMA pledge, is being part of a greater “we”, a “we” that is defined by certain practices and convictions. Hence, the WMA physician’s pledge is much more than only a promise made by an individual; it is a commitment made to a “guild”, to a tradition, to a community that has certain standards of conduct.
Conscientiousness may sometimes entail feeling “compelled by conscience to resist others’ authoritative demands”\(^2\(p^{43}\))\(^2\). B&C cite the example of military physicians who might be commanded by superior officers to act in inappropriate ways. In this context, B&C discuss the difficult issue of conscientious objection, using the metaphor of balance, weighing the one against the other: On the one hand, “there are good reasons to promote conscientiousness and to respect acts of conscience”, but, on the other hand, “some conscientious refusals adversely affect patients’ and others’ legitimate interests”\(^2\(p^{43}\)).

**Nurturing the virtues in medical practice**

It should be clear by now that I do not think virtues grow out of thin air. As expressed by philosopher Saba Fatima, “as in any profession, the environment in which one practices continually molds character”\(^1\(^5\))\(^.\) More precisely, virtues grow when the individual is immersed in a community that embodies them. Virtues are not learned by taking an Internet or classroom-based course (i.e., they cannot be taught), rather, they are learned by interacting with others committed to the same goal. Here, the concept of “professional socialization” seems useful.\(^1\(^6\),\(^1\(^7\))\(^\) As expressed by Dinmohammadi et al, professional socialization has been described in the literature as “the process of internalizing and developing a professional identity through the acquisition of knowledge, skills, attitudes, beliefs, values, norms, and ethical standards in order to fulfill a professional role”\(^1\(^6\))\(^.\) Professionalism, which is hence arguably strongly linked to the nurture of key professional virtues, is something that has to be passed on to and internalized by medical students and residents,\(^1\(^8\),\(^1\(^9\))\(^ but my contention is that professional virtues also need to be upheld, nurtured, developed, and protected throughout one’s carrier as a medical practitioner. Hence, CPD should not only be about biomedical facts\(^2\(^0\)) (although this is, needless to say, crucial), but also about creating an environment in which self-critical ethical reflection on such things as e.g. motives and one’s own emotions can flourish. This kind of “soft” topic should not be seen as something odd or superfluous but on the contrary as a shield that can protect and perhaps even nurture professional virtues in an otherwise often busy and work-intensive field such as the practice of medicine.

This view of virtues arising and being strengthened and upheld in a group of people committed to a common goal stands in clear contrast to the “myth of the lone physician”\(^2\(^1\))\(^.\) This is not to imply that physicians working alone in their own practice (solo practice) would thereby be deprived of the possibility of upholding virtues in their work. It is important to stress that the issue here, as I see it, is not about solo vs group practices *per se* but about the dangers of
professional isolation. Indeed, it is possible to work in a group practice and still isolate oneself from the influence of others, and it is possible to work in a solo practice and still engage with colleagues and other health care personnel in issues related to CPD. My point is that I think loneliness and lack of accountability to a team probably is a risk factor for gradual loss of ethical direction. For the purposes of the present paper, it does not matter whether the team is multidisciplinary or consists of other physicians; what matters is the communal emphasis. Of course, if the team in question does not embody professional virtues such as the ones described by B&C but rather in its communal life expresses the opposite of virtues, the individual will be formed by that. Simply put: Belonging to a team can both nurture and erode virtues, depending on the context.

**Implications for CPD educators**

It is probably not enough for professional organizations to just proclaim and publish value statements or policies. Instead, for professional virtues to grow in the individual, there has to be an environment in which it is possible to reflect ethically about one’s own motivations, drives and feelings. Perhaps one could talk of emotionally competent organisations. In such an organisation, certain values are celebrated and cherished (e.g., the five virtues described by B&C) without their being any taboo concerning the difficulties in achieving them. On the contrary, a health care team embodying professional virtues such as the ones advocated by B&C will allow “negative” feelings and thoughts to come up to the surface, canalizing them into a possibility for growth and self-knowledge. CPD educators working with issues of medical professionalism should therefore be aware of the importance of taking the “culture” of the workplace into consideration. Just telling people what is right and wrong, or just talking about values, will not do. Health care professionals have to be made aware of the fact that they are themselves continuously creating the culture of their workplace on a daily basis, and that they are both shaped by it and shaping it. Metaphorically speaking, part of what we are breathing out comes back to us when we breathe in. Hence, CPD educators should be aware of and in their teaching stress the importance of “professional socialization”. This is a truly interdisciplinary area at the interface between virtue ethics, pedagogical theory and group psychology. The question people need to be made able to ask themselves is not what should we value, but what values do we actually as a group embody?

Such self-reflective questions are perhaps best asked in practice-based small group learning programs, which is alternative model to lecture-based CPD. In Sweden, where the
responsibility for providing health care is decentralized to county councils/regions, a recent report from the Swedish Association of Local Authorities and Regions in cooperation with Linnaeus University showed that reflecting peer-support groups were of value in preventing burnout and disengagement in health care workers.\textsuperscript{26, 27} What this illustrates is that practice-based small group activities need not only be about “hard” biomedical facts; they can also be about “softer” issues, including such things as professionalism and ethics.

**Lessons for practice**

- It has been argued that medical professionalism largely presupposes the existence of a community where virtues relevant to the practice of medicine are embodied and upheld.
- Virtue ethics theory should be considered as an important “reservoir” of insights relevant for issues related to medical professionalism.
- The workplace “culture” is important to take into consideration when addressing professionalism, not least from the point of view of “professional socialization”.
- The interface between virtue ethics, pedagogical theory and group psychology is an interdisciplinary area of great importance for CPD.
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