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Seeking Magis: a Virtuous Approach to Medical Practice

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SEEKING MAGIS: A VIRTUOUS APPROACH TO MEDICAL PRACTICE

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Introduction: How Ought We To Live: Magis and the Future Physician

For the last four years, my undergraduate education has been framed within the context of a single question, "How ought we to live?" This question represents the core of the Jesuit ideal of education. To answer this question, the Jesuits suggest a focus on the concept of *Magis*. Their understanding of the term comes from the Latin motto of the Jesuit order *ad majorem glorium dei* (for the greater glory of God). In terms of my education, however, the definition of *Magis* has been a topic of great discussion. As we will see, *Magis* is not a term that lends itself to a simplistic definition; indeed I believe it is a term that represents an aspect of human life that people must define on an individual basis.

For the sake of argument, *Magis* can be understood as the "better way." Specifically the term implies a "better" way for a lived human life, which for the Jesuits is cultivated through education. This, however, is at best a murky area of understanding. Intrinsic to the idea of a "proper" life is a necessary set of social, historical, and moral understandings that dictate proper action, which is why *Magis* is such an elusive and potentially controversial topic. The question for many becomes, how can there possibly be a "right" way for all humanity to live? More importantly, *who* is to say what is right? The most obvious and correct answer is that there is *not* one right way for all humanity to live, certainly no one person to say that there is. "Human diversity is too obvious to require proof," says James Drane, "but it is also true that human actions have not just a host of unique characteristics, but commonalities as well, which provide a basis for

generalization" (Drane 9). Here I make my first and most critical point of clarification; people must answer for themselves, from within the context of their own life, what the "better way" is for them. This is precisely why the Jesuits ask a question instead of providing an answer. *Magis* must be understood as the endeavor by each individual to choose what they want from life and to achieve it the best way they know how as free individuals. Another way to think of *Magis* might be to say that it is the embodiment of personal responsibility that necessarily accompanies human freedom. I believe that with freedom comes a certain responsibility to live well. The term "*Magis*" is the generalization of that responsibility. This thesis investigates the way that *Magis* can be applied to the life of an individual. Specifically, we will look at modern medicine and see how the concept of *Magis* can be applied to its practice in order to relieve human suffering and promote a better way of life for persons. We will start at the macro-level of society with a broad understanding of a better way to live and then narrow the discussion to the specific practice of medicine in later chapters.

To this end, the first chapter will serve as a template for generalizing our understanding of *Magis*. In this chapter, the argument is constructed as a comparison between our current understanding of morality and persons represented by John Rawls and the more ideal perspective that coincides with *Magis* put forth by Alasdair MacIntyre. Rawls is the modern proponent of a historical philosophical tradition that culminates in an understanding of humanity as a fundamentally self-interested mode of being. He views people as rationally self-interested beings who necessarily find themselves within society and who are entitled to justice within that society as free and

equal citizens. To achieve justice in a selfish world, Rawls suggests the formation of principles of justice from behind a veil of ignorance. The veil of ignorance, for Rawls, presupposes the selfish nature of humanity and attempts to utilize that rational self-interest to create principles that would necessarily be agreed upon by all rationally self-interested people.

On the other hand, Alasdair MacIntyre argues that first we ought to cultivate virtues so that we might understand what rules and principles are trying to accomplish in the first place. MacIntyre argues for the attainment of goods internal to social practices; he believes that through the attainment of internal goods we might achieve an existence that could be called "the better way." MacIntyre's view of humanity is that we are essentially creatures of potential. He believes that with proper attention to character development and the cultivation of the virtues human actuality can be something greater than that of self-interested individuals who just happen to live together. To clarify what the argument is saying we might turn to another voice, Martin Heidegger, who suggests that, "higher than actuality stands *possibility*" (Heidegger 85). Using Heidegger, the first section can be called an argument between what many believe is the *actuality* of human existence and what others see as the *possibility* of human existence; in the end I think we find that Heidegger had a point.

If the first section represents the template, then the second section represents what *Magis* actually looks like, or what we could call the model for *Magis*. As I've already said, *Magis* must be understood in terms of the individual who seeks a "better way." So in hopes of understanding what *Magis* is all about, I offer my own understanding of the

term. I have said that *Magis* can be understood as the better way, but the better way for what? For the individual, *Magis* means the better way for how *I* ought to live. For me, an undergraduate student aspiring to become a doctor, one aspect of my *Magis* means the answer to: how ought a *physician* to live? To answer this question, I address certain problems within the practice of medicine that are fundamentally opposed to the foundations discussed in the first section and indeed the very idea of a "better way." Specifically, we look at the primary theory of medical practice known as Disease Theory. Disease theory represents everything that is currently wrong with the way modern medicine views human suffering and the lives of individual persons. If we apply our discussion of the virtues in the first chapter to the practice of medicine in the second, we find that we can create a new theory of medical practice that could be called a "better way," because it gives to humans what humans are owed in the treatment of their suffering.

In addition, we will see in the first chapter that a virtuous approach to morality demands that moral decisions not be removed from the context in which they are found. This means that when we talk about morality and practice we must consider the social context in which we find them. For medicine, we find that it exists within a predominantly Rawlsian world built on rules and regulations to which the whole practice must adhere. Historically, in a world built on rules and laws, a person is only defined as "good" so long as they follow the rules set in place to guide action. For medicine, this understanding of good, when combined with disease theory, has created a practice that is only concerned with solving biological puzzles and treating diseases instead of the *person*

who is sick in bed. To correct this, we will apply the concept of *Magis* and Virtue Theory in order to create a better understanding of what a "good" doctor ought to be.

The third chapter could be called *Magis* in practice. Here it should be noted that *Magis* is not a question of *what,* but rather a question of *how.* In this section I discuss the ways that *Magis* ought to be applied to the actual practice of medicine. Specifically, in this chapter we examine different applications of *Magis* to the practice of biomedicine and certain functional aspects of the doctor-patient relationship. Because we are changing the way medicine is understood on a *theoretical* level, we must also carry that change through to the level of *praxis*. In addition to these modes of practice, this chapter also investigates current techniques that are being used to improve clinical medicine with *Magis* and the virtues in mind. Specifically, we look at the emerging concept of evidence-based medicine and suggest that with minor modifications to the way it is understood by researchers and physicians it could be used to alleviate suffering with extreme efficiency.

This thesis is a partial answer to my own question of "How ought we to live?" In short, I believe we ought to live better than we currently do. I believe that if we have the potential to live with compassion in our hearts and knowledge in our minds then we ought to *do* it. I believe if we have the potential to create a society where humans are given what they are owed as humans then it is our *responsibility* to do just that. Throughout this thesis what constantly comes under fire are modes of thought that I consider outdated or indeed dangerous. For many of us, our vocation represents the way we most readily interact with society; as such, each individual's *Magis* will primarily be

concerned with this aspect of life. I use medicine as my example because it represents the larger context in which much of my own life will be carried out.

Heidegger suggested that, "higher than actuality stands possibility." I believe this is because until now humanity has not had the courage to exercise possibility to the point of actuality. This thesis suggests that *Magis* represents the first step towards possibility becoming a human reality. If we expect to achieve human possibility, however, we must extract ourselves from this Rawlsian system of a rule-based morality. Disease theory will show us our tendency to try and reduce human lives to "manageable" proportions and Rawls will show us the societal context in which this takes place, but in the end I think we will see that this way of thinking is holding us back from what we have within ourselves to be. Specifically, we have the potential to be *Human.*

Chapter I: The Virtue Centered Approach

Magis, no matter what the lived reality may be, is fundamentally a philosophical principle. It is an abstract concept of a "better way," which I have suggested is premised by the question "How ought we to live?" This question, however, does not lend itself to a ready-made answer. We can say that *Magis* is the answer to the question "How ought we to live," but immediately we find ourselves in a circular discussion about what *Magis* actually is. On one hand, we can say that *Magis* is an ideal, a principle to be followed that can help us answer the question. On the other hand, we can say that *Magis* is a sort of understanding that must be gained through education and knowledge, and through that pursuit we will come to know the answer to the question. Further still, however, we can also say that *Magis* does not have one single definition or an *a priori* meaning; so how best to define *Magis?*

For this thesis, *Magis* will be defined as a philosophical mode of being. This means that the term *Magis* will be used to suggest something specific about the way human beings find themselves within the world. Historically, different philosophers have suggested different modes of being that have characterized their philosophical institutions; for Descartes it was *Cogito ergo sum* (I think therefore I am), for Heidegger it was called *Dasein*, for Nietzsche— the Will to Power. All of these thinkers were trying to convey some fundamental understanding of what could readily be called the human condition. For the Jesuits, from whom *Magis* comes, they understood the human condition as a journey towards a "higher" existence. For this thesis, we can think of *Magis* in similar terms. Specifically, *Magis* will be used to define the human condition in

which persons strive to achieve excellence. We can call it the driving force within human nature that pushes us to be better human beings and better persons within a social world. To understand this notion, however, we must have some basic understanding of the world in which humans find themselves.

The first chapter of this thesis will be dedicated to uncovering this mode of being known as *Magis*. Specifically, we will look at the current popular ideas concerning the nature of the world and the condition in which humans find themselves within it, then compare this current conception with new ideas that can be understood in terms of *Magis* and the "better way." For this purpose I will appoint a representative for the current progression of philosophical thought as it concerns the human condition. The benefit of utilizing a single representative is that it allows for a critical appraisal of the position while at the same time allowing a realistic scope for the argument. The cost, however, is that many might argue that no single representative can possibly embody the complete philosophical makeup of an entire society. While I do acknowledge the limitations of a single representative, I believe that John Rawls does embody the philosophical foundations and current philosophical trends of modern society, which I am questioning in this argument.

Rawls represents a philosophical institution of western thought. The primary benefit of using a philosopher like Rawls to represent modern society is that he actually is a modern philosopher, which means he is not completely detached from the concerns and limitations of modern society. At the same time, his ideas come from a tradition founded in the thoughts of Aristotle, Kant, and Locke, essentially making his writings a

summation of western philosophical traditions up to this point in time. It seems justified using his ideas as a representative because he writes with the full consideration of these thought-traditions already passed and because of the popularity and merit attributed to him by modern society. As Rawls puts it, "Institutions, when properly understood from a philosophical point of view, are rational, and developed over time as they did to attain their present, rational form" (Rawls 3). So, assuming that Rawls represents the evolution of political philosophical thought up to this point in time, which I understand is a stretch, but a necessary one for the sake of argument, we will address the moral foundations that make up our society as Rawls understands it in order to find a place for *Magis* within that society. Achieving *Magis* requires that it first be understood at the level of the individual before it can be applied to the larger realm of society as a whole. With this in mind, we begin by looking at the modern understanding of individual persons.

If we examine the socio-historical evolution of the individual we can see a trend that begins in the 17th century with the Renaissance in Europe and leads us to a modern conception of what the individual has become. Specifically, we can see the progression from the emphasis on the whole society to the emphasis on the unique individual. "The recent stress on individual differences rather than on political equality is a predictable new direction of self-image," says Dr. Eric Cassell (Cassell 33). For Americans, political individualism is fundamental to our way of life, yet it is only in the last century that the individual has become the unit of unprecedented freedom. The image of the individual as the quintessential unit of the human condition and the parts of life it stresses are currently leading societal conceptions and understandings; a brief reflection on the

institutions of consumerism and the modern corporation should demonstrate this beyond a doubt. The fundamental unit of modern society, not its foundation but the actual reality, is me, myself, and I. This necessarily means that a certain view of governance was adopted to accommodate this perspective; I maintain that it is a Rawlsian one. Though it does not seem obvious at first due to Rawls' focus on political equality instead of individual freedom, we must look at the assumptions that lead to his ideas to understand how this came to be.

An unmistakable assumption made by Rawls and indeed by *many* other philosophers is the inherent selfishness of individuals within society. Selfishness is obviously not a new concept; we could say that animal survival instinct is inherently selfish and predates *all* societal conceptions even if we did not have centuries of history detailing corruption and tyranny to corroborate the idea that people are selfish. Rawls, however, does not simply understand people as selfish beings. Rawls suggests that people are citizens, citizens being "regarded as free and equal and as both reasonable and rational" (Rawls 8). What he means by this is that people can be expected to act in a certain way given that they are rational beings. Specifically, Rawls understands people to be rationally self-interested beings, meaning that they take action to do what is best for themselves within society because to do otherwise is unreasonable. With this conception of a Rawlsian citizen, we can now say that what Rawls is arguing for is a just society in which rationally self-interested people exist together. If Rawls is arguing for a just society then he must naturally devote himself to overcoming the selfish nature of

mankind, the enemy of justice. He has several ways of doing this, but before we discuss them explicitly we must briefly return to this idea of a just society.

Earlier I mentioned that *Magis* could be understood as a "mode of being." In philosophy, the concept of a "mode of being" means a way in which people necessarily find themselves within the world. To understand this better, we can say that we did not choose to be born— we simply existed one day. Since we did not choose to be born, we can necessarily say that we found ourselves within a specific world not of our choosing. For example, I found myself in a world where I existed as an American male living in Wyoming in the beginning of the 21st Century. For Rawls, his understanding is very similar, namely that we do not enter the world voluntarily. "Rather we simply find ourselves in a particular political society at a certain moment of historical time" (Rawls 4). In light of this existence, Rawls suggests that, "we might think our presence in it, our being here, is not free," since we did not choose to be here (Rawls 4). He then asks the question, "In what sense, then, can citizens of a democracy be free?" which he answers by stating that:

> "One can try to deal with this question by viewing political society in a certain way, namely, as a fair system of cooperation over time from one generation to the next, where those engaged in cooperation are viewed as free and equal citizens and normal cooperating members of society over a complete life. We then try and formulate principles of political justice such that if the basic structures of society— the main political and social institutions and the way they fit together as one scheme of cooperation— satisfies those principles, then we can say without pretense and fakery that citizens are indeed free and equal" (Rawls 4).

Rawls is suggesting here that through cooperation over time we can construct a society that ensures people can exist as free and equal citizens so long as we have principles of justice that are being maintained by the various societal institutions. Essentially, this is

how Rawls "solves" the problem of human selfishness; he suggests that a society governed by principles of justice will allow people to exist as rationally self-interested beings so long as they follow those principles, which surely reasonable and rational people ought to do. The question becomes, what principles of justice ought we to follow and who is going to formulate them?

Rawls maintains that the citizens making up the society are responsible for defining their own terms of cooperation, which can be understood as a social contract (Rawls 15). This manifestation of the social contract is similar to the one suggested by John Locke. The central tenant of the social contract, as Rawls understands it, is that, "the fair terms of social cooperation are to be given by an agreement entered into by those engaged in it;" society, in return, will provide security for the freedom used in its creation (Rawls 15). Rawls believes that a social contract is necessary because free and equal citizens cannot agree on any moral authority or moral order of values or the dictates of natural law, which is a notion that any observation of our modern political climate will validate (Rawls 15). Rawls refers to this phenomenon as "reasonable pluralism," which is essentially the societal manifestation of intersecting lives and ideals of numerous rationally self-interested people. For this reason, Rawls believes the social contract to represent the form of cooperation that can be agreed upon and also maintained by a just society. In response to the earlier question, the social contract answers the *who,* but *how* members of a just society are to form a social contact is still in question. Rawls believes that in order for it to be a truly just agreement the parameters of the social contract must be formed from within what he calls the "original position."

The original position is a hypothetical position that can be called a "veil of ignorance," where those defining the principles of justice and thus the parameters of the social contract are ignorant of their own place within society. Those in the original position must represent nothing more than one voice of a free and equal person who is rationally self-interested and devoid of social ties, social responsibility, and personal feelings or attitudes. In fact, the parties involved in the original position do not even know their "race and ethnic group, sex, or various native endowments such as strength and intelligence, which is assumed to be within normal range" (Rawls 15). Those in the original position must also know nothing about the nature of their decisions, meaning they cannot know how their decisions will affect their own lives. In short, *those in the original position cannot know whether or not they will necessarily be the ones who benefit or lose from the principles they select.* Rawls maintains that any terms decided on in the original position must necessarily be fair and just, because they will eliminate any bargaining advantages naturally accrued by some members of society over time (Rawls 16). For example, in the current American political system corporations and conglomerates wield great power and authority over the political process. From within the original position, however, that affluence and power cannot be used to affect the outcome of any decision simply because it does not "exist" behind the veil of ignorance. What the original position equates to is an objective perspective for deciding moral authority (Rawls 16). Rawls believes the value of an objective perspective is that it shows what society regards as fair conditions for citizens and what it regards as acceptable restrictions on reasons for accepting or rejecting certain political principles

(Rawls 85). In short, objectivity for Rawls means a system of liberties and justice founded in reason and rationality. In this sense, Rawls represents the very best aspects of our society and the fundamental ideals on which it was founded, which is why I believe he is an acceptable voice for our current system. His original position represents the ideal for our legislative body, while his conception of the social contract built around that position provides the structure for our republic, our liberties, and justice for all. Up to this point, Rawls' argument represents the foundation of what is necessary for the formation of a just society by free and equal citizens, which is the goal at which our society aims but which we have yet to reach. It should be noted that an important step must be made from the theoretical towards the actual formation of a functioning society. In reality, a society does not subsist on theory and conjecture alone. At this point, what can be said of Rawls is that he establishes a firm need for a just society to govern free and equal citizens, but his answer for a formulation is still in the form of a hypothetical position that has no real world principles. For this reason it becomes necessary to have a discussion about the functional foundation of our society.

Thus far, the discussion of the original position, the social contract, and the mode of human existence has left us in a hypothetical state where free and equal persons who are rationally self-interested are deciding on principles of justice to govern society. Rawls believes that this discussion will necessarily yield two primary principles of justice. The first principle of justice is that there must be a system of basic liberties for all, such as those upheld by our Bill of Rights. The second principle, which he calls the difference or maximin principle, is that inequalities are only justifiable so long as they

benefit the least advantaged members of society (Rawls 42). For example, if the rich have greater basic rights or greater opportunities than the poor, these inequalities can be justified only if they are to the advantage of the poor and are acceptable from their point of view. The importance of the difference principle is unparalleled in a Rawlsian universe; it is in place to assure that justice remains the central theme in political society. In addition to the difference principle, however, society must also find a way to delineate a set of basic liberties, which history tells us is no easy task. If we look at real world attempts to delineate a set of basic liberties that coincide with a Rawlsian conception of justice, we arrive at what can best be described as a rule of law.

Our society is one of laws; this is what many of us love about our country. When we are presented with a given situation, the likelihood of our choosing one outcome over another will most probably be directly tied to the rule or law that governs that outcome. It seems to me that the primary benefit of a law is that an individual should never be confused about a proper course of action; in a rule of law there will be a governing principle to follow when faced with moral choices. For instance, when a physician is presented with a patient requesting an abortion, his decision to perform that procedure will most likely be governed by law, either by law of the state or the law of a particular religious tradition of which he is a part. It is characteristic of an absolute rule of law that in the absence of a specific law governing an outcome, any decision the actor makes is permissible i.e. it cannot be against the law. This characterization, however, shows a fundamental flaw with such a system. It does not seem proper that simply because a scenario escapes the foresight of those in the original position, or those making the laws,

that any action should be permitted simply because there is no rule to govern it. More importantly, in such a system a law is not only the fundamental unit of function; it is the ultimate indicator of right and wrong action. A person in such a society is only considered to be a "good" if they abide by the laws meant to guide action. In this society, "rules become the primary concept of the moral life. Qualities of character then generally come to be prized only because they will lead us to follow the right set of rules" (MacIntyre 119). As such, a system predicated on a rule of law seems inadequate both when faced with a foreign precedent and when expected to produce citizens of venerable character. Though a marvelous benefit of the original position is that the laws and principles born of it are necessarily just, we can see an example here of what the original position and the rule of law cannot do; they cannot account for a realistic application of those principles.

In my opinion, this is a major shortcoming of both a rule of law and of a Rawlsian conception of just society. If the social contract is in place to promote the original position, which in turn is in place to set up a system of basic liberties that will protect freedom and implement the difference principle in order to ensure justice, then it seems critical to me that a Rawlsian society be able to promote the moral character of citizens so that society can account for foreign precedents. This argument can be understood another way. If we look at the means used by Rawls, we can characterize them as objective ideas concerning the governance of society. In fact that is exactly what the original position represents, an objective construction of how society ought to be, which Rawls not only supports but also praises. In response to this perspective, some

philosophers maintain that the main disadvantage of a Rawlsian line of argument is that it only works so long as one *remains* in the original position. They believe that, when applied to reality, objectivity is insufficient (Trappenburg 421). We can see this plainly by examining objectivity itself, a trait that modern philosophers describe as characteristic of the modern self, "the capacity to detach oneself from any particular standpoint or point of view, to step backwards, as it were, and view and judge that standpoint or point of view from the outside" (MacIntyre 126). This ability is what characterizes Rawls' objective stance and also characterizes a rule of law, for what is a law but a distanced verdict placed on a given moral choice? However, though praiseworthy by modern standards, objectivity carries with it an inherent removal from particularity and accountability, which is the final flaw with a rule of law. As I have already stated, if rules are the primary component of a moral life then qualities of character are only praiseworthy if they lead us to follow the right set of rules. Rules in and of themselves require no connection between the actor and the decision; in such a system nothing need be understood except the parameters of action allowed within the rule of law. In this way, *all* accountability is removed from the process of moral decision-making, which a modern world cannot tolerate, especially if justice is the goal of modern society.

There are other philosophers, however, who believe that, "morality is always to some degree tied to the socially local and particular and that the aspirations of the morality of modernity to a universality freed from all particularity is an illusion" (MacIntyre 126-127). Where Rawls, on the other hand, says that abstract conceptions "are used to gain a clear and uncluttered view of a question seen as fundamental by

focusing on the more significant elements" (Rawls 8). In other words, while Rawls maintains the value of the original position so that personal bias will not cloud the outcome, MacIntyre suggests it is impossible to act morally when detached from the social context in which the dilemma is found. To me this seems apparent. Though Rawls maintains that society exists with "reasonable pluralism," I believe that if individuals within society do not begin to reach towards common goals it will degenerate completely once pluralism has reached a sufficient volume. If the desired result of morality and ethics is a societal understanding that allows for continuity and preservation of humanity as a collaborative effort, which I believe it is, then any applicable ethical conception must be framed and understood within that context. In short, we *cannot* divorce the principles and foundations of an ethical understanding from the society or individual in which it will be applied if we expect to *achieve* true justice. A Rawlsian objective perspective requires that we distance ourselves from the subjective nature of a particular dilemma, but a moral dilemma is one that necessarily arises from an incongruity between a given moral tradition and a subjective stimulus that is at odds with that traditional understanding. What is desired from a moral judgment is the reconciliation between the moral tradition being challenged and the stimulus that caused the confusion, preferably with the moral tradition in question still intact after the outcome has been determined. This shows us that it becomes impossible for any individual to confront a moral dilemma from an objective perspective, simply because to do so would eliminate the entire basis for the dilemma.

I should point out here that Rawls does go out of his way to explain that his formula for justice is not a system of "moral doctrine," but is merely a "political conception" (Rawls 19). However, I feel it is impossible to discuss the place of political philosophy in society without a direct connection to the moral nature and makeup of that construct. Rawls goes further by suggesting that politics is but a *part* of the moral domain, but I feel this is an escapist tactic at best, a tactic representative of modern thought and a problem-solving tactic which remains unacceptable. The ubiquitous use of this tactic alone, by Rawls and by society as a whole, explicitly demonstrates that our culture is less and less concerned with moral action and accountability so long as action is dictated by a rule of law— rules have indeed become the primary concept of the moral life. I maintain that morality has become a subset of politics and political philosophy instead of the other way around. What this means for this argument is a critical revision of where our society stands. *Magis* demands we formulate a better way for our society to cope with moral problems in lieu of relying on an insufficient rule of law.

To achieve this, we can say that, "rules and regulations falter when expected to bear the full weight of right and wrong" (Drane 7). There is no accountability! Though there is punishment for disregarding a rule or law, there is inherently no justification and so no way of furthering the moral nature of society. If society expects to further morality then moral action must necessitate particularity and accountability. A particular individual has a responsibility to act a certain way because of his place in society, whatever it may be, which means he is accountable to other members of the community. A doctor has a responsibility to first do no harm because he is accountable to his patients

and to the integrity of his profession, as well as to his own conscience. It seems quite reasonable that when faced with a moral decision a person in full command of a complex and discriminating mind is perfectly capable of distinguishing the morally correct action, especially if attention is paid to a moral education. Alasdair MacIntyre suggests that, "the modern view for the justification of the virtues," which would represent the particular character traits necessary for moral action, "depends upon some prior justification of rules or principles" (MacIntyre 119). This is essentially indicting a Rawlsian society, suggesting that it was only *after* we decided on the rules necessary for society that we began to build the character traits necessary to enforce them. He then goes on to ask a very astute question, "suppose we attend to *virtues* in the first place in order to understand the function and authority of rules" (MacIntyre 119).

For modern philosophers, this represents a new and intriguing conception of morality. If rules are not sufficient, then what should be the standard of moral decision-making? The answer for MacIntyre is the Virtuous Actor, the individual in whom the virtues of right moral action are cultivated and exercised. The conception of the virtuous actor, says MacIntyre, allows for a perfect synthesis of morality and action. In fact, this perspective must necessarily have a new definition of morality, because instead of morality being judged by the extent to which one follows the rules, the application of moral character and consequences of ethical decisions become the standard by which we must measure morality. But how does one judge something like moral character or the outcome of an ethical decision?

For MacIntyre, morality is always tied to the socially particular. As such, the context in which a decision is made will determine the moral nature of that decision. For this reason, MacIntyre's moral conception revolves around what he calls a *practice.* MacIntyre defines a practice as, "any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended" (MacIntyre 187). Obviously this is a definition in need of explanation. For this thesis, it might be better to define a practice as the social realm where an individual has the potential to attain excellence. For example, checkers is not a practice, but chess is. Bricklaying is not a practice, but architecture is. Throwing a football is not a practice, but the game of football is. What is critical to the notion of a practice is the idea of *attaining excellence* within a social role. If we look at tic-tac-toe for example, we cannot call it a practice. Though one could be called a good tic-tac-toe player, there are diminishing returns on what can be gained by endeavoring to achieve excellence at playing tic-tac-toe. In this example, there is a simple mathematical rule where if a certain starting move is made between two sufficiently knowledgeable players the game will always end in a draw. Similarly, one could certainly be said to be a better bricklayer than someone else, but there is an attainable ceiling on how well someone can lay bricks, meaning that it cannot be characterized by the pursuit of excellence such as architecture certainly can.

Another way to understand this notion of a practice is to look at its roots within modern virtue theory. To say that morality is tied to the socially particular says much about the nature of moral duty. For MacIntyre, his conception of a practice stems from the place of the virtues within heroic societies. "In such a society a man knows who he is by knowing his role in the social structures… A man in heroic society is what he does…to judge a man therefore is to judge his actions. By performing actions of a particular kind in a particular situation a man gives warrant for judgment upon his virtues and vices; for the virtues are those qualities which sustain a free man in his role and which manifest themselves in those actions his role requires" (MacIntyre 122). Thus, to enter into a modern practice means to accept a certain social role, namely a role that will be judged based on how well that role is performed based on the exercise of the virtues. For this thesis, the specific nature of that judgment is based on the pursuit of excellence within that given role. In this way, we can say that the exercise of the virtues becomes the standard for a given practice.

To identify the standards for a given practice means that the social role is characterized by the cultivation of all virtues within that practice that promote the achievement of excellence. For example, if the virtue of wisdom is characteristic of a good architect, because wisdom ensures that the architect has factored in all the variables required to ensure a building stays standing in hurricane winds, then that virtue characterizes excellence within the practice of architecture and ought to be a standard for the practice. To take this further, if morality can be defined in terms of the virtues, which represent those standards of excellence that characterize a practice, then the social role

occupied by that practice represents the necessary accountability of the individual to society, which is lacking in a rule of law. For example, the architect who cultivates wisdom fills a specific social role, which is characterized by society's need for buildings and structures such as bridges. We can then understand the moral nature of a virtue through the responsibility that the architect has to the rest of society to build safe and sturdy structures. In other words, it is not only praiseworthy for an architect to be characterized by wisdom and to continually pursue the excellence of wisdom within his practice, but because of the responsibility he has to the lives of those who use his structures (i.e. the social role) it is morally reprehensible to lack wisdom as an architect, hence society's distress at the sight of a collapsing bridge.

The virtues themselves seem to represent something of an enigma for many philosophers. Many critics of a virtuous approach still believe that the very idea of a virtue is far too subjective and imprecise to possibly be a foundation for morality or ethics. They argue that virtues represent an archaic form of morality particular to Aristotle and ancient Greece. Margo Trappenburg, for example, points out that the communitarian argument for a virtuous approach is nothing short of nostalgia. She thinks critics of this argument will say that ancient virtues are not the shared understandings of modern society, that what worked for ancient Greece is far too detached from modernity to be relevant. She also points out that older traditions disappeared for a reason, that better ideas came in to replace them (Trappenburg 419). What these appraisals represent, however, is a criticism of the use of *ancient* virtues to uphold morality in *modern* society. This thesis, along with MacIntyre, is arguing for the establishment of *modern* virtues

relevant to a *modern* society. For example, MacIntyre maintains that there are three primary virtues of modern practices that are ubiquitous to all practices, namely justice, truthfulness, and courage. Justice represents the accountability of a practice to the rest of society, whereas truthfulness is a requisite of any relationship within modern society and since morality cannot be removed from the socially particular, truthfulness is a requirement for maintaining social relationships. Similarly, for MacIntyre the virtue of courage is necessary for all moral actions within the modern world. The very definition of a moral decision is one in which an individual's character will be tested. As such, the cultivation of the virtues is not an exact science, and so it requires courage by the actor to exercise the virtues in a situation that is morally ambiguous. These are not virtues of Ancient Athens or of Homeric poetry, they are specific character traits that MacIntyre believes are necessary for individuals to perform a social role within a modern moral society.

We can further this idea of the virtues as a modern construct by looking at what they achieve for the modern individual. "Every activity, every inquiry, every practice aims at some good; for by the 'good' or 'a good' we mean that at which human beings characteristically aim… Human beings, like members of all other species, have a specific nature; and that nature is such that they have certain aims and goals, such that they move by nature towards a specific *telos*" (MacIntyre 148). In terms of this thesis, we can understand *telos* as one definition of *Magis*; a final cause or the end at which human life characteristically aims is one of a better way seeking a specific form of *Good*. *Good* then, in reference to a virtuous morality, "is the good of a certain kind of life" (MacIntyre

190). By living a certain kind of life, that is, by existing within a practice and within society, we tend to have goals and aims for our actions towards a specific end. MacIntyre is asserting that the cultivation of the modern virtues is what will lead us to a moral life and fulfill our nature by reaching that certain *telos* or *good*. "It is the *telos* of man as a species which determines what human qualities are virtues" (MacIntyre 184). This is why we can say that different practices ought to have different virtues which characterize their standards, because each role within a practice has its own *telos* that perpetuates the overall *telos* of the human race. Specifically, "a virtue is a quality the exercise of which leads to achievement of the human *telos*. The word arête, which later came to be translated as 'virtue', is in the Homeric poems used for excellence of any kind;" so it might be better to say that the cultivation of the virtues allows for the achievement of pure human excellence, the *telos* of the modern age (MacIntyre 184).

The notions of "good" and "excellence," however, still seem somewhat abstract. To say that *Magis* is that which aims at a certain *good* or *telos* is far too abstracted to be considered an applicable notion. So if we take a moment and return to the actual application of the virtues I believe we can gain a deeper understanding of the life at which the virtues characteristically aim. For MacIntyre, any decision results in the attainment of one of two types of goods, either internal or external. External goods are those that "when achieved they are always some individual's property and possession, such as money. Moreover characteristically they are such that the more someone has of them, the less there is for other people" (MacIntyre 190). External goods represent part of what Rawls has called "primary goods." In modern society we often judge the

"success" of an individual based on their ability to attain these goods. When discussing the moral nature of a person, however, these goods tend to be those in modern society that undermine character, such as power and fame. I will say though that within the realm of external goods lie those things that we as people need to survive. For the sake of this argument I am going to reallocate Rawls' definition of primary goods to mean those things that humans need to perpetuate life, things like food, shelter, and clothing. In reference to the achievement of external goods, it is critical to say that the achievement of this type of good is not an achievement that promotes *Magis* or is aimed at human *telos*, but is the good achieved from a certain type of life which seeks external goods, which by definition is not a moral life.

MacIntyre's concept of internal goods, however, is more complicated. He describes internal goods as, "the outcome of competition to excel, but it is characteristic of them that their achievement is a good for the whole community who participate in the practice" (MacIntyre 190). A specific example of an internal good would be Picasso's conception of cubism; achieved through dedication to his art, it enriched the way artists and lay people are able to see and experience the world around them through the practice of painting by giving them a new and exciting way to view the physical world. In other words, by Picasso cultivating the virtues of the artist, such as creativity and innovation, he was able to achieve a sort of excellence within the practice of painting that single-handedly advanced the practice of painting towards the human *telos.* Though this may seem like a bold claim, what Picasso was able to do with cubism changed the way people and artists saw the entire world around them. It even provided inspiration to other

practices and encouraged them to step back and try to see the world from a different perspective. This example shows how, through the exercise of the virtues that are critical to the life of an artist, Picasso contributed something, an internal good, to the entire community. Within each practice is the possibility for the attainment of internal goods. There are first of all the internal goods represented by the excellence of the products and the practitioners, such as cubism, but in addition to this MacIntyre suggests a second dominant type of internal good, "for what the artist discovers within the pursuit of excellence in portrait painting… will constitute the whole life for someone who is a painter, but it is the painter's living out of a greater or lesser part of his or her life *as a painter* that is the second kind of internal good to painting" (MacIntyre 190). In other words, the second type of internal good is the *telos* of the practice of painting; the *good* gained by living the life of a painter can only be achieved by living life as a painter. It is important to remember here that internal goods, unlike virtues, are *specific* to a given practice, for the *telos* gained by exercising the virtues of a painter will only ever mean the achievement of excellence within the practice of painting.

With this in mind then, I would like to redirect the argument back to our earlier discussion of *Magis.* I said before that *Magis* represents a better way towards the human *telos*, but as such I still maintain that the specific better way must be defined by each individual that sets out to find that *telos.* As such, in my own search for *Magis* and the human *telos* I must answer for myself "How ought *I* to live." I have said already that a given social practice tends to have its own understanding of *telos*, this is clear because we know that each practice must necessarily fulfill its own role within society and as such

has its own ends. For me, as a free and equal citizen, I have chosen my own role to be that of a medical physician, which means that my own mode of being or *Magis* is defined in specific terms with the end result being the *telos* of the practice of medicine. As such, the next chapter will investigate the specific *telos* and *Magis* of the practice of modern medicine so that we might gain a better understanding of how one goes about finding *Magis*.

It is important to point out why virtue theory is being used to critique the current morality of society and why it is the best method for doing so. I have already said that the virtuous approach accomplishes two things. First, it promotes the achievement of excellence and *telos* within a given practice while retaining the accountability of that practice to society; and second, it allows for a real world application of morality and ethics by leaving the moral decision to the discriminating mind of the person who will eventually make that decision. A Rawlsian approach can only establish a rule of law as a system of basic liberties and then it relies on abstract principles such as the difference principle to enforce those liberties. To me, it seems that the virtuous approach is the only one that makes practical sense. As we have seen, relying on rules and abstract principles is insufficient because it does not work in reality and has no accountability. What is needed is a practical approach to moral decision-making; "any philosophical method chosen must pay attention to *praxis* and well as *theoria,"* says Edmund Pellegrino (Pellegrino 47). Peter Singer stresses that, "an ethical judgment that is no good in practice must suffer from a theoretical defect… for the whole point of ethical judgment is to guide practice" (Singer 2). It has already been said that the primary criticism of Rawls

is that his argument only works so long as one remains in the original position, so the first step towards reconciliation must be in the direction of realistic applicability. MacIntyre stresses that, "the implicit epistemology of the virtuous world is one of thoroughgoing realism" (MacIntyre 129). This means that any knowledge we have concerning the virtues and their application, especially the benefits they bring to a moral decision, comes directly from their application in reality. It seems clear that virtue theory provides the best vehicle to create a system of ethical accountability in the *real* world. What is critical to this understanding of the virtues is that this theory is one that accounts for *praxis*—the virtues are meaningless unless they are applied to the real world. MacIntyre suggests that, "it is worth remembering Aristotle's insistence that the virtues find their place not just in the life of the individual, but in the life of the city" (MacIntyre 150). For this reason, the next chapter focuses on the application of the virtues to the practice that I have chosen for my own role within society, the practice of clinical medicine.

Chapter II: Theory in Medicine: Morality and the Virtues

In this section we examine the practice of clinical medicine as the context for the application of the virtue theory discussed in Chapter 1. Though we have taken the first step down the path towards a virtue-centered morality, we will soon see that a virtue-centered approach requires a complete paradigm shift in the way society thinks about both morality and people. In the first section we discussed the foundational changes necessary for this way of thinking. Primarily, I have asserted that morality cannot be founded in principles divorced from praxis and that it is also necessarily tied to the socially particular. In addition, the first section also demonstrated the need for this paradigm shift by enumerating how our rule of law is insufficient to support a modern morality. Now that the need for change is established, we can begin to look at *how* the application of the virtues can lead us to a practical application of *Magis* within the practice of medicine.

Medicine seems like the logical choice to demonstrate the principles I am addressing in this argument. In addition to being a practice expected to uphold the highest moral standards, medicine is one that deals exclusively with human lives— the realm for a virtuous morality. As far as a paradigm shift in the way we think about persons and morality is concerned, what is true of medicine will be true of all society. Medicine is currently under indictment from various physicians and philosophers who champion the virtue-centered approach. The claims they make are specific to the practice of medicine, but echo similar ideas this thesis challenges in the first section. The primary charge they bring against medicine, as well as society, is that "the whole world of human

persons, as well as the special respect which persons are owed, can disappear from day to day activities and the meaning of doing good is collapsed into doing things efficiently" (Drane 2). In short, human goodness is being sacrificed for institutional "progress."

In this section I hope to demonstrate what the paradigm shift in thinking will look like by using medicine to demonstrate the necessary changes in explicit terms. As I have already said, part of the paradigm shift necessary for virtue theory is the way we think about people. Medicine is no different; if the practice of clinical medicine hopes to find its place in a virtuous world it must redefine the way it thinks about people and persons. Unfortunately, medicine is an ancient institution devoted to thinking about people in a very specific way. For medicine to adapt to a new way of thinking it will require several changes in the foundations of medical theory, an alteration to the goals of medical practice, and the addition of the virtues to clinical medicine. However, before we can begin to enumerate the virtues and the virtuous practice of medicine we must be very clear about what exactly the practice of modern medicine is and more importantly what it must become.

The practice of medicine can best be understood in terms of the dominant theory of medical practice. Dr. Eric Cassell suggests that, "how well a theory that is fundamental to medicine *works* has a profound impact on how effective doctors are, on how they behave, on relations within the profession, on relationships with patients, and even on the power of the profession in general" (Cassell 5). He goes on to suggest that this is a difficult topic because clinical practitioners tend to view themselves as "realists" who do not seem to believe there is a theory for clinical practice. He states simply that,

"whether doctors like it or not, human action is inevitably theory driven; we act as we do because we have a concept— a theory— about what will be the consequences of our actions" (Cassell 5). We have seen this in practice already in the previous section with our discussion of Rawls and MacIntyre; it is plain to see from that discussion how theory, whether it is political or moral, underlies most aspects of our modern society. It is worth remembering Dr. Cassell's point that the place of theory in modern society should not be underestimated.

Historically, the prevailing theory of medical practice is known as disease theory, which postulates the necessity of identifying and classifying a given ailment in order to treat it. Fundamentally, disease theory looks at sickness in a very specific way; it looks for a *cause* to bodily affliction. Classical disease theory implies specificity of disease, "that every disease entity is produced by a quite particular cause, that different diseases cannot arise from the same cause, nor can different causes produce the same disease" (Cassell 7.) For clinical medicine, subscription to this theory means that physicians *think* about diseases and patients in a very particular way. Specifically, the attention of the physician being drawn toward the physical causes of disease necessitated the invasion of medicine by science, allowing for a systematic approach to the classification and diagnosis of disease. "This hunt for precision in diagnosis has characterized medicine ever since" (Cassell 7). What this invasion means for the practice of medicine will be discussed explicitly in the next chapter, but what is important for our understanding here is that the implementation of disease theory caused a very pronounced diversion of

thought towards the *causes* of disease and away from the *person* in whom the disease presents.

For modern medicine, we can see that this focus on disease causality and the science to find them has left the practice severely crippled. “Physicians came to believe that to know the disease and its treatment is to know the illness and the treatment of the ill person” (Cassell 19). However, modern medicine cannot deny the true nature of disease, “the same disease in different individuals may have a different presentation, course, treatment, and outcome depending on individual and group differences among patients… the uncomfortable fact remains that doctors cannot get at diseases without dealing with patients— doctors *do not treat diseases, they treat patients*” (Cassell 19). For medicine this means a *required* place for the individuality of persons. In fact, if we listen to voices within the practice we hear the same thing over and over again with regard to the place of the person in medicine. Dr. Eric Cassell is the Clinical Professor of Public Health at Weill Medical College of Cornell University and an attending physician at New York-Presbyterian Hospital. He states very plainly that, “none can pretend that knowing medical science alone represents sufficient, effective command of the knowledge and skills necessary for effective doctoring…To be successful in treating the sick and alleviating suffering, doctors must know more about the sick person and the illness than just the name of the disease and the science that explains it” (Cassell *vii-xiv*). Dr. Edmund Pellegrino, the Professor Emeritus of Medicine and Medical Ethics at Georgetown University, suggests that, “The patient is not a passive object to which technique is applied…medical science, therefore, becomes medicine only when it is

modulated and constrained in unique ways by the humanity of the physician and patient" (Pellegrino 24). In addition, Dr. Jerome Groopman, the chair of medicine at Harvard Medical School, says that, "Medical care — in all of medicine, not just primary care — is a human interaction between patient and doctor within a context and in a social system" (Groopman 99). This discussion even dates back to a lecture given by doctor Francis Weld Peabody in 1925 where he said, "the secret in the care of the patient, is in caring for the patient" (Groopman 54). Each of these esteemed physicians is essentially saying the same thing, that medicine is more than simply the treatment of disease. As such, there ought to be a theory that represents a "better way" to practice medicine that accounts for the *person*. In the first section, MacIntyre suggested that virtue theory does account for the socially particular, in this case the person to whom medicine is applied. Specifically, it is MacIntyre's conception of the internal good that will account for the place of the person in medicine, which will be discussed in detail in the next chapter. For now we can simply reiterate that virtue theory dictates morality cannot be detached from the socially particular and that in medicine it is personhood that represents a major component of the social context for the practice.

Personhood for medicine, however, is a difficult topic. It is not only the subjective and unknowable nature of people that is difficult for the physician, but it is also the way the institution of medicine historically understands and educates physicians about the role of the individual as it concerns medical practice. "The idea of person is not static, it has gradually changed over history. The split between mind and body that has so deeply influenced our intellectual history and our approach to medical care was proposed

by René Descartes to resolve certain philosophical issues" (Cassell 32). Descartes' idea was to make a distinction between the understanding of the mind and the understanding of the body in an attempt to resolve contemporary conflicts arising between religion and science. He thought that reality could be reduced to either the perspective of the body, which contained all empirical data, or the perspective of the mind, which encompassed himself and God and whose objectivity elicited truth (Descartes 19). The impacts of this dichotomy cannot be overstated; by separating the mind from the physical world Descartes was able to alter the way all of western culture thought about the self. For a Cartesian understanding, the *mind means self*, "he will never bring it about that I am nothing so long as I shall think that I am something…I am, I exist, is necessarily true every time I utter it or conceive it in my mind" (Descartes 18). Like Descartes, medicine also reduced the individual to a single mode of being, but in this case the advent of disease theory reduced the individual to the body instead of the mind; for a medical understanding— *body means self*. With disease theory, everything that did not have to do exclusively with the body was segregated to the subjective realm of the mind. It is important to note here that this is not only a definitive segregation for medicine it is a qualitative one. Historically, medicine felt that the mind was outside its realm of concern because the mind was objectively unknowable. As such, the mind was relegated to the realm of the subjective and the spiritual and was considered a lesser form of understanding when compared to the objective scientific understanding that dominates clinical medicine. Attempts have been made to circumvent this problem by creating a "science" of clinical medicine, but "establishing a scientific basis for dealing with values

and human qualities [is] doomed because science cannot deal with what it does not recognize as existing" (Cassell 20). It is this understanding of medicine as a "pure science" that has created the practice being criticized by the various physicians cited above.

Along with those physicians, this thesis is arguing that persons *cannot* be simplified into their individual parts of minds and bodies. Personhood then must be understood and defined as a sum of the parts of persons; it is the combination of the social, historical, cognitive, emotional, and physical aspects of a person which all come together to make the whole. In fact, it is not only medicine but all of society that has an obligation to start thinking in this manner. "Human diversity is too obvious to require proof," says James Drane, "but it is also true that human actions have not just a host of unique characteristics, but commonalities as well, which provide a basis for generalization" (Drane 9). Though no one can *completely* know who or what an individual person is, it does not mean we know *nothing* about what it means to be an individual and a person. For medicine, this means that the practice must now conceive of persons in a very different manner than bodies afflicted with disease. Towards this new understanding, James Drane, the professor of clinical medical ethics at Edinboro University, suggests that:

> "Human beings can never be understood in an exhaustive or final way, but we can know something about being human and correspondingly, know that certain conduct is right because it respects, promotes, and is owed to humans. Correspondingly, we can know something about illness, the needs of persons who are ill and the history of the profession which stops to help ill people. Certainly, our understanding is limited, and certainly there are complications introduced by cultural variations, but there is also trans-cultural agreement about what constitutes both human good and good medical practice" (Drane 10).

The task we are faced with then is coming to an agreement about the good owed to humans by the practice of medicine and establishing standards in order to make sure it is provided. I stated in the first chapter that the virtues provide the definitive standards for a given practice. For medicine, the standard for good will be those virtues that provide what is owed to persons by the practice. But before we address the virtues we must be in agreement about what that good for persons actually is. To this end, Dr. Eric Cassell suggests that the good, or the goal of medicine, breaks down into a very simple maxim that justifies the addition of the virtues as the cornerstone of what is owed to persons and accords persons their proper place within the practice of medicine. Because "the test of a system of medicine should be its adequacy in the face of suffering… suffering must inevitably involve the person— *bodies do not suffer, persons suffer*" (Cassell *v*). "Because patients have personalities, character, virtues, vices, fears, thoughts, projects, and loves, these dimensions, too, have a place in the way they are treated by doctors" (Drane 22). In short, treatment of *suffering* and not the treatment of disease ought to define the good for the practice of medicine. In order to alleviate suffering, however, we cannot continue to try and understand the world from within an exclusive disease theory framework. We must acknowledge the constantly subjective nature of humanity, and we must accept that a persons' suffering cannot be understood only as a physical affliction.

This notion of suffering, however, presents an interesting dilemma for the clinical practitioner. It is one thing to say that a doctor has a responsibility to treat the person and

not the disease lying in the bed in front of them, but it is quite another thing to apply medical science to the spirit, mind, or soul of a person in the clinical setting. Here then it must be said that, "the implicit epistemology of the virtuous world is one of thoroughgoing realism" (MacIntyre 129). This means that the focus of this investigation must remain the *practice* of medicine, so we can ask ourselves, what does the treatment of the whole person looks like to the clinical practitioner? To answer this question, I believe our starting point should be similar to that of a clinical approach. If we start by understanding the very nature of suffering and determine its causative agent, we can then address the best way to treat it.

First, however, we must correct a common misperception about the nature of suffering as it is understood by modern medicine and disease theory. Disease theory, because of its understanding of personhood and its ties to the empirical parts of persons, tends to associate and limit suffering to the symptom of pain, as in "pain and suffering." However, "although pain and suffering are closely identified in the minds of most people and in the medical literature, they are phenomenologically different" (Cassell 34). We can understand this using the simple example of an individual suffering at the distress of another, for example a mother suffering because of her child's medical crisis or the suffering family of a patient diagnosed with cancer. It is clear that these persons are not in any physical pain, but in such cases these people do consider themselves to be suffering. Pain, however, obviously has a large role in the nature of suffering. Through clinical observation Dr. Cassell tells us that, "people in pain often report suffering from pain when they feel out of control, when the pain is overwhelming, when the source of

pain is unknown, when the meaning of pain is dire, or when the pain is apparently without end… In these situations, persons perceive pain as a threat to their continued existence— not merely to their lives but their integrity as persons" (Cassell 35). This suggests that pain can be understood as one source of suffering for patients, but certainly not the only one. In fact, based on clinical observations, Dr. Cassell tells us that "suffering can often be relieved *in the presence of continued pain,* by making the source of pain known, changing its meaning, and demonstrating that it can be controlled and that an end is in sight" (Cassell 35). This implies, to an extent, that once we ascribe meaning to suffering it ceases to be suffering. The idea that suffering does not necessarily imply pain then tells us much about the responsibilities of the clinical physician in the alleviation of suffering. If pain is not the sole cause of a person's suffering, though it certainly can be, then it is up to the physician to be diligent in finding the cause of that suffering and do what can be done to correct the problem.

To this end we must know the true nature of suffering. "Suffering," says Dr. Cassell, "occurs when an impending destruction of person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner" (Cassell 32). For example, Dr. Cassell presents us with a case he encountered within his practice:

> "A 35-year-old sculptor with cancer of the breast that had spread widely was treated by competent physicians employing advanced knowledge and technology and acting out of kindness and true concern. At every stage, the treatment as well as the disease was a source of suffering to her. She was frightened and uncertain about her future but could get little information from her physicians, and what she was told was not always the truth. After her ovaries were removed and a regimen of medications that were masculinizing, she became obese, grew facial and body hair of a male type, and her libido disappeared. When tumor invaded the nerves

> near her shoulder, she lost strength in the hand she used in sculpting and became profoundly depressed. At one time she had watery diarrhea that would occur unexpectedly and often cause incontinence, sometimes when visitors were present. She could not get her physicians to give her medication to stop the diarrhea because they were afraid of possible disease-related side effects (although she was not told the reason). She has a pathologic fracture of her thigh resulting from an area of cancer in the bone. Treatment was delayed while her physicians openly disagreed about pinning her hip… Each tomorrow was seen as worse than today, as heralding increased sickness, pain, or disability— never as the beginning of better times. She felt isolated because she was not like other people and could not do what other people did. She feared that her friends would stop visiting her. She was sure she would die.
>
> This young woman had severe pain and other physical symptoms that caused her suffering. But she also suffered from threats that were social and others that were personal and private. She suffered from the effects of the disease and its treatment on her appearance and abilities. She also suffered unremittingly from her perception of the future" (Cassell 29-30).

This case demonstrates two important facts about the nature of suffering. First, this young woman's suffering was not limited to physical symptoms, so appealing to disease theory for treatment is useless. Second, that her treatment was also one cause of her continued suffering. This is important because if the social role and accountability of the modern physician is the alleviation of suffering, then to alleviate or minimize suffering the physician must consider the consequences of the treatment he or she offers. In short, the virtuous physician's responsibility is to do more than just treat the disease or its symptoms; the physician has a responsibility to understand what causes the patient's suffering in its entirety and do whatever is within their power to stop it. In this example, the physicians could have alleviated the patient's apprehension about the treatment by being honest or improved her feelings of isolation and depression by simply acknowledging her fears about the treatment they were administering. In short, this is an

example of the physicians ignoring the whole person they were treating in favor of treating the disease.

It is important to note here that, "the doctor's help is called assistance, a term which in its etymological roots means "to stand alongside another (*ad-sistere)*" (Drane 21). The role of the virtuous physician is not one of paternal guidance such as the care demonstrated above in the example of the sculptor; it is an interaction between equal persons. In the end, it is not only the scientific knowledge possessed by the physician that makes him or her vital to the patient, it is also the humanity and understanding within them that makes the alleviation of suffering possible. For this reason, the humanity that characterizes the physician should be the very best that an individual can muster; this is why the cultivation of the virtues is so vital to the future of medicine and indeed society, because it means striving to be the best person and physician that an individual can be—this is *Magis.* The humanity of an individual, however, may seem like an impossible thing to apply to the practice of medicine, especially for those who view it as a purely objective science. To these critics, I believe James Drane makes a valid point when he says, "virtue and character are neither purely subjective nor strictly ideal categories. Objective standards for both can be derived from the very nature of the doctor/patient relationship. Sometimes, however, these standards function as ideals, serving more as goals toward which human conduct points but never achieves" (Drane 17). At this point in the argument it must be made clear that the cultivation of the virtues is just that, an endeavor. It is not possible to attain perfection as a human being; this is an undeniable fact of life. However, "rather than being beyond human accomplishment, ideals are very

much a part of even ordinary human behavior, in that our ordinary acts are modified by that to which we aspire. Ideals impinge on life and this is especially true in medicine" (Drane 19). Though we may never attain the complete mastery of a specific virtue or ideal, it is the constant effort to better ourselves as humans that will characterize a virtuous life and simultaneously define *Magis*. However, if virtue theory expects to find its roots in medicine, it cannot be grounded in ideals alone. The objective standards that Drane refers to are a necessary aspect for a practical application because they provide the foundation on which to build individual character.

To understand this in its entirety we must briefly return to our general discussion of virtue theory in the first chapter. MacIntyre states that, "Every activity, every enquiry, every practice aims at some good; for by the 'good' or 'a good' we mean that at which human beings characteristically aim… Human beings, like members of all other species, have a specific nature; and that nature is such that they have certain aims and goals, such that they move by nature towards a specific *telos*" (MacIntyre 148). I then went on to say that each practice has its own specific *telos* at which it characteristically aims. For medicine, we can now say that its responsibility is to "aim" at the alleviation of suffering. However, I have also now stated that certain objective standards are necessary in order provide a foundation for the virtues that will aid in that alleviation. I must note here that the objective standards to which I am referring are not commensurate to Rawlsian objectivity. Where Rawls seeks an objectivity necessarily detached from the particular, I am suggesting an objective standard is acceptable only so far as it embodies the *telos* at which a practice aims. To separate this idea from Rawlsian objectivity, I will call a

virtuous *telos* a moral "principle of duty," which suggests a correlation to a specific end instead of an objectivity detached from the socially particular. We can now say that, "In ethical theory, moral virtues are generally, and perhaps always *correlated* with moral principles of duty…in order to know which virtues are appropriate in medicine, we first need to know what *ought* to be done, and a theory of moral principles of duty presumably provides such an account" (Beauchamp 17). In part, this has already been addressed with the discussion of suffering by saying that the alleviation of suffering is what ought to be done, but the earlier discussion is incomplete because it lacks the principle of duty that will provide the means to accomplish that end. Medicine, like all practices, needs a principle of duty to guide the ideal character development necessary for the implementation of virtue theory. In short, "The language of virtues buttresses, rather than *supplants*, the language of principles of duty because both duties and virtues are required to make moral responsibility a 'counterpoise to self-interest' and thus to direct the physician to the best interests of the patient" (Beauchamp 17). So what is now needed for our discussion is the specific principle of duty that will guide the practice of medicine.

"That specific form of good (*bene)* which the doctor does (*facere)* for persons who are ill is summarized under the principle of *beneficence*" (Drane 32). Beneficence represents the principle of duty for virtuous medicine. Specifically, the beneficence model of medical practice attempts to discern the modes of practice that will bring about the greatest good for the patient while minimizing harm. "The goods which are peculiar to medicine and which doctors publicly vow to accomplish, are precisely those referred to by this term: curing disease, relief of [suffering], restoring lost function etc" (Drane 33).

So far, the principle of beneficence has been addressed indirectly throughout this argument in our discussions of *telos* and the "good" for medicine in relation to the relief of suffering. However, if we are to understand the place of the virtues and formulate a practical application of these principles we must address the beneficence model of medicine directly.

Historically, beneficence was understood in terms of Hippocratic teachings, which are best summarized in *Epidemics*[1], "declare the past, diagnose the present, foretell the future; practice these acts. As to disease, make a habit of two things— *to help, or at least do not harm*" (Beauchamp 30). The modern sources of Hippocratic teachings also emphasize beneficence as the responsibility of the physician to benefit the patient and at the very least to do no harm. For Dr. John Gregory, one of the most important figures for this historical tradition, "the physician's moral role is itself understood in terms of beneficence" (Beauchamp 32). In other words, the morality of the physician is tied specifically to the duty he or she has to their patient's best interests. For Gregory, this responsibility translated into the concept of sympathy (Beauchamp 33). Gregory's idea was that a sympathetic physician would be able to see sickness from the perspective of the patient and thus identify with and understand the patient's circumstance. Further, in reference to the virtues of the physician, Gregory believed that, "in all cases of conflict between the physician's personal interests and his or her obligations to patients, virtue requires that the latter come first" (Beauchamp 34). This notion of the "patient's best

[1] Hippocrates, "Epidemics," in *Hippocrates*, trans. Jones, Vol. I.

interest," however, creates the foundations for some very serious objections to the beneficence model as the principle of duty for medical practice.

In contrast to the principle of beneficence is the autonomy model, which understands the values and beliefs of the patient to be the primary moral element of medical practice. Within this model, if the patient's values conflict directly with the values of medicine or of the physician, it becomes the moral prerogative of the physician to respect and facilitate the patient's self-determination of their medical care (Beauchamp 42). Intrinsic to this model of care is the idea of self-governance, the idea that an autonomous individual has a right to control the outcome of his or her own life. A key aspect of this model has been developed through western legal concepts. The right of self-determination is a legal right in western culture and is designed as a protection for patients by limiting the physician's power. "Legal rights are a way of a protecting the patient from unwarranted intrusions— such as surgery without consent, involuntary commitment to a mental institution, and public disclosure of information contained in hospital records" (Beauchamp 43). Though these protections are both warranted and necessary, obvious conflicts can arise between a doctor's understanding of the patient's best interest and the patient's own understanding. In other words, what the patient wants and what medicine wants for the patient do not always coincide. "From this position, the burden of proof rests on one who would intervene by restricting or preventing a person's exercise of an autonomy right" (Beauchamp 45). In order to illustrate this conflict we can turn to a clinical example:

> "In the spring of 1973, a twenty-six-year-old college graduate named Donald Cowart was discharged after three years of military service as a jet pilot… Two

> months later he and his father were appraising some rural property about 135 miles east of Dallas. They had unknowingly parked near a leaking propane gas transmission line, and when they returned to start their car, the ignition spark set off a large explosion that engulfed both father and son in flames. After temporary admission to a local hospital, he and his father, both in critical condition, were transferred by ambulance to Parkland Hospital in Dallas. Later, Mr. Cowart would learn that his father died during the two-hour trip to Dallas.
>
> Mr. Cowart suffered extensive second- and third-degree burns over sixty-eight percent of his body. His ears were largely destroyed, and he was blinded in one eye. Because of gangrene, his fingers were later amputated to the knuckles. His right eye was enucleated (entirely removed) and his left retina was found to be partially detached and the cornea scarred. It was doubtful sight in that eye could be restored and was surgically sealed shut to prevent infection. Mr. Cowart also underwent skin grafting and daily bathing in a Hubbard tank. He was given painkillers before each tubbing, but not enough to relieve the pain of the tubbing and the dressing of the wounds. Mr. Cowart described the pain as excruciating and said he would sometimes pass out when the treatments were completed.
>
> Throughout the months of treatment Mr. Cowart generally displayed mental alertness— though he recalled some delusional periods very early in his treatment. On many occasions he insisted that his treatments be stopped. Had he been discharged from the hospital, death by infection was inevitable, but he said he intended to take his own life, not to allow death to occur by infection. Since Mr. Cowart's physical condition prevented him from leaving the hospital on his own; his discharge required the cooperation of his physicians… his request to stop treatment was not acted upon by his physicians and the daily baths continued. However, he refused skin grafts to be performed, and this refusal was accepted by his physician, although reluctantly.
>
> A psychiatrist was consulted to ascertain the legal competence of Mr. Cowart. He found the patient to be informed, coherent, logical in his reasoning, and rational— thus mentally competent. Nonetheless, the psychiatrist thought Mr. Cowart's request for release was premature and ill considered in light of medical improvements that might yet be achieved. He therefore tried to convince Mr. Cowart to accept further treatment. Mr. Cowart was adamant, however, in his decision to refuse treatment and to die. He insisted that he had the right to control his fate" (Beauchamp 80-81).

Later he consented to skin grafts in the interest of shortening his hospital stay and lessening the pain of his burn wounds and was eventually discharged and returned home to East Texas (Beauchamp 81). The argument here between beneficence and autonomy is plain to see. Mr. Cowart's physicians felt that they understood what was in the long-

term best interest of their patient; after all he did survive and eventually learned to take care of himself. Mr. Cowart, on the other hand, felt that he had the right to determine the outcome of his own life and was acutely aware that he would never again be able to live even a semblance of the life he once knew. In addition, "he was appalled at the failure of those charged with his case to protect what he regarded as his civil liberties" (Beauchamp 82).

The question becomes then, which model of medical practice dictates correct moral action? If we accept the beneficence model, then the physicians in this example acted rightly. They felt that the patient could not foresee his own long-term interests because the extreme pain of his recovery coupled with depression was influencing him wrongly; as such, they felt it was their moral obligation to their patient to continue the treatment and save his life. However, if we accept the autonomy model as the moral principle, the physicians acted wrongly. They disregarded the autonomy of a medically and socially competent patient in the interest of pursuing their own agenda and their personal values. If this is the case, they are not only morally accountable to the patient and the practice of medicine, but legally accountable because they did indeed violate the intrinsic right of self-determination of a competent patient. This dilemma has been a great source of turmoil for me personally. The problem demonstrates perfectly how medicine fails as an objective science. Because medicine deals exclusively with the lives of persons, there will always be dilemmas of morality that appear as shades of gray *outside* the understanding reserved for the human body. However, I believe the conflict between beneficence and autonomy *does* have an answer.

When I first attempted to solve the conflict for this thesis I petitioned the faculty of the university for their opinions on the dilemma and received some very good advice. At the time I was arguing for the position of the beneficence model and trying to resolve my belief in beneficence with my belief in necessary autonomy. My position was that it must be the responsibility of the physician to always fight for the good of the patient. "That is what defines medicine," I said, "there can be no such thing as a moral practice of medicine without beneficence as the primary principle; doctors exist for their patients, period." However, I also felt that autonomy of the patient was of the utmost importance. I don't believe that one person ever has the right to dictate choices in the life of another, whether they are right or not. The fact is, we can never be one hundred percent sure about the outcome and consequences of our decisions; as such, choices *must* be our own. Freedom is the right of all persons; if morality dictates anything at all it must be this. How best to resolve the moral dilemma then? In truth, I don't think there is a dilemma. Though I have spent some time outlining the apparent problem between beneficence and autonomy, I think that the apparent dilemma is not one of morality, but once again, the problem is one of understanding. When I was talking with Dr. Tom Howe he asked me a very astute question pertaining to the understanding of this dilemma. When I was discussing my belief that it was the moral responsibility of a physician to argue and indeed fight for the best interests of their patients, he stopped me for a point of clarification; he asked, "How do you understand beneficence? In other words, how do you define the best interests of the patient?" At the time I couldn't give him a definitive answer because of the implications the question held. When I thought more about it, I

realized that this is the fundamental misunderstanding that creates the dilemma between autonomy and beneficence.

As I've already pointed out, the conflict between these principles arises when the physician's understanding of a patient's best interests conflict with the patients' own understanding of those interests. The understanding held by medicine is that either it understands something about the case that is somehow not understood by the patient or that the patient is mentally incompetent and thus incapable of arriving at that understanding. While teaching a course on medical ethics, Dr. Cassell noticed that, "in case after case the discussion showed that students believed that doctors had an obligation, independent of their patient's desires, to utilize their knowledge and technology to save lives and do what could be done for individual diseases" (Cassell 135). In the case of Donald Cowart, the physicians felt that his pain and suffering was inhibiting him from seeing the long-term picture that could be his life. For Mr. Cowart's physicians, preserving life was their sole concern for their patient. They thought that if he could just survive then he could possibly be happy again. This is the first alteration to medicine's understanding that must be accepted if the dilemma between autonomy and beneficence is to be resolved, *preserving life for life's sake is not consistent with the actions of a benevolent physician*. Surviving is not always the right course of action for a medical patient. I believe this is an understanding that will be difficult for most, especially those who argue for the sanctity of life, but the nature of medicine is such that death is an inevitable factor in its practice. As biological organisms we will all eventually die, this is a fundamental and inescapable part of life. Though under no

circumstance should a physician ever stop working and fighting for the life of a patient. There comes a time when he or she simply must accept the place of death in life and respect the free choice of a competent and autonomous individual.

The following letter from a physician, published in the *New England Journal of Medicine* in 1980, explicitly illustrates my point. Though the author argues for a program of euthanasia, this is a different moral discussion outside the concerns of this argument. Instead, I ask the reader to focus and reflect on what the author has to offer us as to the role of death in life:

> "To the Editor:
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> As one who has had a long, full, rich life of practice, service and fulfillment, whose days are limited by a rapidly growing, highly malignant sarcoma of the peritoneum, whose hours, days, and nights are racked by intractable pain, discomfort, and insomnia, whose mind is often beclouded and disoriented by soporific drugs, and whose body is assaulted by needles and tubes that can have little effect on the prognosis, I urge medical, legal, religious, and social support for a program of voluntary euthanasia with dignity. Prolonging the life of such a patient is cruelty. It indicates a lack of sensitivity to the needs of a dying patient and is an admission of refusal to focus on the subject that the healthy cannot face. Attention from the first breath of life through the last breath is the doctor's work; the last breath is no less important than the first.
>
> Consent by the patient with a clear understanding of this act, by the patient's immediate family, by the family physician, lawyer, minister, or friend should violate no rules of social conduct. There is no reason for the erratic, painful course of final events of life to be left to blind nature. *Man chooses how to live; let him choose how to die* (emphasis added). Let man choose when to depart, where, and under what circumstances the harsh winds that blow over the terminus of life must be subdued.
>
> Frederick Stenn, M.D.
> Highland Park, IL[2]" (Beauchamp 86).

[2] Frederick Stenn, "A Plea for Voluntary Euthanasia," *New England Journal of Medicine* 303 (9 October 1980): 891.

This is an extreme example where medicine will continue treatment because it feels treatment serves the best interest of the patient. Dr. Stenn, however, obviously feels very different about the nature of medicine's obligation to him. This means that this thesis has a responsibility if it expects to resolve this dilemma; it must once again be very clear about what medicine owes the patient.

As I have already said numerous times, the responsibility of virtuous medicine to the patient is to treat and alleviate suffering. In terms of beneficence, the role of a physician is not to preserve life at any cost, but to *serve* life in the best interests of their patients. This never means, however, overriding the autonomy of their patients due to a perceived conflict between the interests of treatment and the interests of the patient. I must note here that autonomy only applies to patients who are medically competent to make autonomous decisions. Both the practice of medicine and the law have standards for making this judgment and should be carefully considered in conjunction with autonomy. Dr. Cassell suggests that, "Discussions with patients, if at all possible, should be made at a time when they are able to express themselves clearly *about the things that matter to them*. Some patients have to be forced into these conversations 'kicking and screaming.' Nonetheless, physicians have an absolute and unremitting responsibility to understand their patient's aims— and come to terms with them— no matter how much time and how many attempts are required. (Doctors would do no less to stop bleeding)" (Cassell 283). Dr. Howe asked me how I defined the best interests of the patient. In truth, no one but the patient can define what his or her best interests are. I have said that the guiding question for this thesis is, "How ought we to live?" I must now say that this

question is one that no person should ever attempt to answer for any one else. Why then does medicine feel as though it sometimes has this right?

It seems as though this entitlement stems from the complex nature of medical science itself. "Doctors try to base their actions on their superior knowledge of results and chances for success or failure for a patient whose wishes and beliefs the doctors must somehow discover not only with regard to this moment of decision, but in terms of the patient's long standing ideas. Since mistakes are always possible, doctors must err on the side of life without using this as an excuse to reduce the burden of discovering what the patient *really* wants" (Cassell 138). The point of this discussion is basic, that there is no inherent conflict between the models of beneficence and autonomy. Though I could say that the principle unit of a virtuous morality must be the autonomy of the patient, I think this is only a partial answer to my inquiry. It seems more appropriate to say that a physician who is truly acting benevolently will always respect their patients' autonomy and recognize the place of their own values within the doctor patient relationship. In other words, to override a patient's autonomy is to act *against* the principle of beneficence, so I believe we can say that the principle of duty for medicine *is* beneficence. This being said, I must reiterate that, "the doctor's help is called assistance, a term which in its etymological roots means "to stand alongside another (*ad-sistere)*" (Drane 21). This is to say that beneficence in medicine does not create a paternalistic relationship where a doctor influences autonomy. Instead, we must understand that the medical relationship is one in which *two* persons interact in order to meliorate the presence of suffering. This means there is a necessary place for a doctor's personal

feelings as well as the patient's. Indeed great importance must be attributed to the feelings, attitudes, and understanding of the person who is the physician. Everything I have said in this argument thus far about the nature of persons applies to the physician as much as it applies to the patient. "Doctors are people who, because of their special knowledge, are empowered to act by virtue of the trust given by patients, and who thereby acquire responsibility. In their actions on behalf of the sick person, endangered by the possibility of failing their responsibility, doctors become threatened by what threatens the patient. *Doctor and patient are bound in a reciprocal relationship*—failure to understand that is failure to comprehend clinical medicine" (Cassell 72). It is, "the intersection of their values, together with those of medicine, science, and society, that creates a nexus of choices and priorities. It is the unraveling of that nexus for this patient, here and now, that constitutes medicine" (Pellegrino 24). Because doctors are people, and because they have this unique bond of responsibility to patients, it is abundantly clear why the cultivation of character traits and virtues is absolutely necessary for the clinical practitioner. It is the virtues that will allow the person who is a physician to uphold the principle of autonomy *in accordance* with the principle of beneficence.

Now, with our understanding of the goals and theory of virtuous medicine we are ready to discuss the specific virtues of clinical practice. I have already discussed the danger of an abstracted standard for moral action and the need for a morality founded in praxis, so in order to determine the necessary virtues of the practicing physician we will focus on "developing a catalogue of character traits dictated by the needs of patients and the nature of medical acts" (Drane 32). "The goal of cultivating virtues is to make the

fulfillment of duties to patients a matter of established behavior, rather than a constant struggle to enforce the demands of moral principles" (Beauchamp 17). For the clinical practice of medicine, "its essential acts (diagnosis, treatment, [relief of suffering], function restoration, caring) have a recognizable structure, which serves as a standard for virtues. Certain habitual behaviors can be identified which contribute to the fulfillment of a doctor's professional commitment and meet the nearly universal expectations of people who are ill" (Drane 19-20). To this end, I have asserted that first and foremost the virtues must be founded on the principles of duty specific to medicine, which have been discussed at length. Second, they must give to persons what persons are owed in the treatment of suffering. Finally, the virtues of medicine must account for the subjective and complex nature of persons existing within the social practice. With these stipulations in mind, I have outlined five virtues whose cultivation represent the minimum requirements necessary for medicine to be considered a moral and virtuous practice as MacIntyre understands it.

First, if the principle of beneficence is going to be the foundation of practice, then the most basic virtue for the clinical practitioner is that of benevolence. "Before the good (*bene)* can be done (*facere),* the good (*bene)* must be willed (*volere).* *Benevolence* refers to the commitment or will to carry out medical acts according to the highest ethical standard. It refers to wishing (*volere)* a patient well or being disposed to attend the patient's needs" (Drane 33). Cultivating the virtue of benevolence means nurturing the desire to help others. To say that benevolence refers to the will means that it is not just a desire to help that is requisite for the physician, it is the conscience choice to place the

needs of another at the forefront of all action. I would even go so far as to say that the virtue of benevolence is the answer to a common criticism of the modern physician:

> "More and more physicians today, not just in our culture, but all over the world, have become functionaries either of the state or of some other enterprise. The functionary also tends to develop character traits: he cares only about performing his function or doing his job and doing just enough to meet the minimum demands of the employer. The interest of the bureaucratic doctor shifts from the patient to the job requirements" (Drane 44).

The cultivation of benevolence is designed to prevent just such a travesty. By cultivating the will to help others we can then cultivate other specific virtues that will help the physician remain focused on the patient and provide the proper standard of care to those who suffer. I must reiterate here that benevolence cannot override autonomy; to cultivate the will to act in the best interest of the patient means also cultivating an understanding that the wishes of a patient override the perceptions of the physician. Benevolence, as well as all the virtues to follow, represents the necessary character of the physician. As such, the practice of benevolence demands that the personhood of the physician never *supplant* the personhood of the patient. This can prove to be a difficult task for the physician. It may mean that the physician sometimes suffers because his own character conflicts with that of the patient. This is the nature of being a doctor; it means making the difficult choices and then living with their consequences. We will see, however, that through the cultivation of other virtues, the character of the physician will also be taken into account and the physician's suffering minimized.

To this end we now turn to the virtue of truthfulness. Honesty in medicine is a difficult prospect. "Many a lawsuit begins with a patient who is angry or dissatisfied about his or her doctor's affability. The word affable in English comes from the Latin *ad*

fari meaning "to speak to" (Drane 47). In the practice of virtuous medicine, no virtue is more founded in praxis than the virtue of truthfulness and its corresponding requisite of good communication. I have said throughout this chapter that the practice of medicine is a humane enterprise between two individual persons. As such, the foundations of this interaction find their natural conclusions in the verbal expression of both the doctor and the patient. If autonomy is the principle duty upon which the virtues are built, then getting patients to participate in their own care necessarily means that the patient has some way of communicating those desires. In short, the importance of good communication, from both sides of the doctor/patient relationship, cannot be overstated. "What the doctor says…creates a reality for the patient and, at the same time, exercises power over that reality. What the doctor says has the power to change the patient, sometimes in very substantial ways— all the more reason why more attention should be given to communication and dispositions to communicate" (Drane 53). Though good communication in medicine and in society has many facets, for virtuous medicine and for this thesis, I will focus on truthfulness as the vital aspect of communication necessary for the relief of suffering and the proper treatment of patients[3].

Truthfulness, unfortunately, has not been a historical virtue of medicine and is not an aspect of medicine about which even physicians agree. In fact, there are many historic writings from the *Hippocratic corpus* to *The Aeneid* to *The Laws* of Plato that suggest lying to patients was not only moral but sometimes necessary in cases with a dismal

[3] For further discussions on medical communication see Roter, Debra and Judith Hall. Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits. Westport: Auburn House, 1993.

prognosis. Some modern clinicians hold the perspective that, "in discussing his patient's condition, the doctor realizes that there are some circumstances when he cannot, for the patient's own good, tell him the 'whole truth'" (Beauchamp 83). This notion, however, is justified using the belief that beneficence, at times, overrides a patient's autonomy, a notion that I have suggested is completely false in reference to the moral responsibility of medicine. However, it seems to me as though reference to beneficence in these tough cases has nothing to do with the patient's best interest, but the squeamish nature of the physicians using the excuse. It seems that this is a disagreeable aspect of the practice of medicine that these individuals would prefer to avoid for their own sake. This, however, is *not* a moral practice of medicine. To understand the place of truthfulness in medicine means truly understanding what beneficence is all about. In order for a patient to *be* autonomous they must have all the facts of their own case. "The virtue of truthfulness is a habit of telling the truth even when it is not convenient or does not serve personal convenience… All truth telling is predicated upon the assumption that the other person has a right to know the truth" (Drane 57-58). There is no case in a free society where a person does not have the right to know a truth about his or her own life. Simply said, "Truth must be spoken benevolently, but it must be spoken" (Drane 60). The virtue of truthfulness then, "refers to a disposition to tell the truth not once, but over and over again" (Drane 56). Cultivating the virtue of truthfulness means consistently and freely choosing to tell the truth in all situations. It means being committed to the truth, even when the truth is a hard reality.

I should say here as well that the truth sometimes means different realities in the doctor/patient relationship. For instance, sometimes being truthful and being benevolent means that a doctor must be realistic about the limitations placed on the patient by the physician's own personhood. For example, Dr. John Jewett encountered a case where a Jehovah's Witness was enduring heavy bleeding due to a ruptured uterus after giving birth to her third child and was refusing blood transfusion. Dr. Jewett argued with the patient and her husband to allow him to save her life, but the couple refused and the mother died. Citing the principle of beneficence, the doctor wanted to override the patient's desires to save her life, but in the end autonomy prevailed (Beauchamp 35-37). For this thesis and my own personal understanding of what makes a virtuous physician, this was the only possible outcome; the mother understood her reality in terms of her faith and was not willing to sacrifice that understanding for physical life. For myself, however, like Dr. Jewett, I do not believe that I could stand by idly and watch my patient die when I know there is something that could be done to save her. For the virtue of truthfulness, this means that the reality of care is probably such that I would not be the physician of this patient. Being truthful to the patient, I would need to explain openly and honestly, before I agreed to be her obstetrician, that my own understanding of reality is in conflict with her own. Meaning that if I were her obstetrician, I would not allow her to refuse blood transfusions should a complication arise due to the pregnancy and that if she was not comfortable with that then she would need to find another physician. It is not morally wrong to be honest with a patient about the physician's own reality and it is not wrong to refuse to be this patient's physician in a non-emergent setting. In fact, I would

say that it is morally negligent to agree to be this patient's physician with full knowledge about how I would react in an emergency; such action is synonymous with a lie.

Since truthfulness can be such a difficult enterprise then it helps that the virtue of respect augments the cultivation of truth. At the heart of respect are the virtues of benevolence and truthfulness. Cultivating respect for the patient and respect for persons is what allows the individual feelings of the physician to be controlled in the interest of moral rightness. "Respect is elemental in real life because it is derived from the very structure of persons and relationships. Where it is missing or insufficiently developed, both persons and relationships fail" (Drane 68). Though it has to do with feelings towards others, respect is the virtue that disposes the individual himself towards proper action. It is an internalized value that is exercised outwardly by acting benevolently and always speaking the truth. "Even if one believes another to be morally misguided, tolerance and respect are preferable to dismissal" (Beauchamp 21). In reference to the principles of duty, cultivation of the virtue of respect finds its conclusion in autonomy. Respect for the person who is the patient is what necessitates the physician's duty to the patient's autonomy. For example, in the case of the Jehovah's Witness, it is only by having respect for the personhood and views of the patient that would allow a physician to respect autonomy in such a difficult situation. If Dr. Jewett had overridden the mother's autonomy in order to save her life, he would not only have demonstrated his lack of respect for another's perspective on life, but it would have shown he regarded himself and his views *above* those of his patient. Medicine, and indeed all human life, can never be lived morally so long as an individual sees themselves as *better* than others.

In addition, with regard to the practical nature of clinical medicine, respect for patient autonomy will generate clinical cooperation and with clinical cooperation will come clinical results. All too often in modern medicine, patients feel as thought their physician is disregarding their opinions and feelings about the treatment and care he or she is providing. "As a matter of statistical fact, well over 75 percent of all patients sampled in one survey reported just this high degree of frustration with their physicians[4]. They reported being interrupted consistently, not being allowed to finish accounts of their complaints, not having their questions answered, and in general, not being talked to properly" (Drane 48). In fact, another study showed that, on average, doctors interrupt their patients within 18 seconds of beginning a conversation (Groopman 8). Respect is the virtue that demands the physician remain mindful of people; it will remind the clinician that all people are owed something similar in the treatment of their suffering.

In this manner, similar to the virtue of respect is the virtue of justice. "The virtue of justice refers to that strength of character which is required to do what is fair to other persons. The virtue of justice, like the standard of justice, is something real: a disposition which carries over into habitual objective acts of giving to others what is their due" (Drane 105). This, however, is a complex and troubling facet of modern medicine. If a single criticism can be made of our current system of health care it is that it is unjust. Many citizens are either underinsured or entirely uninsured and receive little to no health

[4] The survey was done by Lou Harris and Associates and reported by Victor Cohn in *The Washington Post*. It was also reported in the *Harrisburg Patriot.* Another study with similar results was done by Dr. Howard Beckman of Wayne State University Medical School.

care. It seems pertinent that any system of morality concerning medicine must necessarily address this issue, however, although the troubles that face our health care system are numerous, disturbing, and in dire need of resolution, these problemss are outside the scope of this thesis[5]. As far as the virtuous practice of clinical medicine is concerned, the virtue of justice necessitates a characterization of the physician and not the entire practice of medicine.

What can be said of the just physician, however, could certainly go a long way towards correcting certain problems within the system itself. "The doctor today, with a developed sense of justice as part of his personality, has to be concerned and working to even up, or to rebalance an unequal system, and to compensate or recompense those who have less" (Drane 107). In essence, the just physician has a responsibility to help all those he or she can help with their medical expertise. The virtue of justice is characterized by the universal response of physicians to the call, "is there a doctor in the house?" Justice means that all patients are equal in the eyes of the caregiver and that the physician never refuses a patient in medical need. I say this as a caveat to what was said earlier about Truthfulness; it is a different matter to refuse to be a patient's physician for individual reasons, such as in the case of the Jehovah's Witness, so long as justice, respect, truth, and benevolence are considered as part of that decision. For instance it is not moral under the virtue of justice, or any virtue for that matter, for a physician to

[5] For other Regis honors theses pertaining to this topic, see Hadjimaleki, Sohayla K. Replacing health insurance with health assurance [electronic resource]: establishing the right to health care and the need for reform in the United States. Regis University, 2009. and Kirkpatrick, Tara. Just what the doctor ordered: reformation of the U.S. healthcare system through a dose of preventative and primary care [electronic resource.] Regis University, 2008.

refuse care to the same Jehovah's Witness who is laying on the street bleeding to death. Justice simply means that we cultivate the understanding that all persons deserve the assistance of a doctor when enduring a medical crisis.

Though they certainly seem difficult to discern at times, the virtues of justice and respect become more apparent to the individual when we consider the specific personhood of the physician. The final necessary virtue of the modern physician is that virtue which disposes the individual towards an understanding of respect and justice for persons, the virtue of compassion. Compassion is a virtue of the physician that is constantly referenced throughout the history of the profession in various terms. For example, Dr. John Gregory, who champions the historic ideals of beneficence, refers to a necessary place for "sympathy" in the personhood of the physician. Gregory, writing from the tradition of David Hume, suggests that, "Sympathy allows one to put oneself in another's place so as to feel what the other is feeling and thus become "sympathetic" with the other's circumstance" (Beauchamp 33). For the sake of a modern approach, however, I believe changing the language of this understanding is important to a virtue-centered approach. By referring to this virtue as sympathy, I believe it limits the understanding that can be gained by the physician. Sympathy, to me, suggests a passive role for the physician; to sympathize with someone is in itself the summation of an action. Compassion, however, represents a higher level of understanding that necessitates whatever action is appropriate for the situation. To express the virtue of compassion sympathy is surely needed, but to say that it stops there seems to suggest that the feelings

of the physician go only as far as pity in treatment will allow. Though semantic, I feel this distinction is important.

Compassion is more than simply sympathizing with a patient. Compassion represents a perspective of the world that seeks to incorporate the personal humanity of the individual into the humanity of the collective whole; it is the virtue that connects one person to the next. It is the understanding that was addressed in the first part of this chapter; compassion represents the knowledge about what is owed to humans for the sake of being human. As I've said throughout this section, because we are human we can know something about being human and what is owed to us as humans. "Paracelsus, in a beautiful statement about the place of affect in the doctor/patient relationship said, 'the very deepest foundation of medicine is love…"(Drane 77). Though surely we have reached a precipice of subjectivity at this juncture, we cannot underestimate the necessity of love and compassion in the life of a whole person; they are fundamental aspects of *human* life. As such, the physician requires an intimate and complete understanding of the subject, which is best accomplished through the cultivation of compassion. Possessing compassion allows the physician to incorporate the virtues of truthfulness, respect, and justice into an understanding about the personhood of the patient that will allow him or her to act benevolently. This formula for the character of the physician, meaning the cultivation of the virtues culminating in benevolent action, is what is owed to people as humans. It represents the moral and social responsibility that the physician owes to the practice of medicine and what the practice of medicine owes to society.

I must reiterate here that the virtues are an imperfect practice. To cultivate the virtues means to do just that, to live as best we can, using what we know about nature of human life as our guide. Medicine, as well as the cultivation of the virtues, is a "messy" practice. They are both messy because, as we can certainly see by now, the lives of persons are messy; they are messy because people are imperfect and complex, but this is not a subject for despair. Knowing that people are imperfect and that morality and medicine both require a subjective touch means that we are getting at the core of what it means to be a physician and a person in the modern world. Now, when I address the question, "How ought we to live?" I have a partial answer for myself by knowing more about how a physician ought to live. A physician ought to live by cultivating the virtues in hope of assisting those who need his help. He ought to live with a complete understanding of people so that he might relieve some of the suffering that accompanies the difficult nature of human life.

I suggested in the introduction that this section would be a model *Magis.* To this end, I have suggested specific ways that we might reformulate medicine so that it might once again be considered a practice of excellence. In the first chapter, MacIntyre suggested that this drive for excellence is part of what characterizes the human condition. In other words, he suggests that we find ourselves in the world striving for excellence in all that we do; it is our *telos*. We can see now, however, that certain ways we perceive and understand excellence has limited our ability to reach it. Specifically, we have seen that when we associate excellence with objectivity we necessarily exclude something critical from the human condition, namely the human part. John Rawls and disease

theory have tried to use objectivity to create universal standards for judging the good associated with their various realms of influence. This appeal to objectivity, however, has created a society that has no accountability to the human *telos* so essential to our lives; in medicine this means that suffering is not being treated, in society it means that true justice is not being served. I will say once again that if we expect to truly attain *human excellence* within our own lives then the standards by which we judge that excellence must be standards associated with how good we are at *being human*. A physician should not be judged by how well he understands the mechanism of infection; he ought to be judged by how well he treats the person who comes to him suffering from that infection. Similarly, how good a citizen is should not be judged by how well they follow the laws; they should be judged by how well they understand the necessity for that law so that in a situation not governed by laws they still do the right thing. I hope this chapter has shown us that we do not find ourselves in a world characterized by excellence. Instead, we find ourselves in a world where the pursuit of excellence ought to characterize our lives; this is *Magis.* In the next chapter we will continue with our discussion of medicine in order to better understand modes of action that can lead us to find *Magis* within a practice. It is important to remember that *Magis* is not a question of *what*; it is a question of *how*. To this end, we will now look at specific ways medicine needs to change in order to meet the standards of excellence established by our discussion so far.

Chapter III: Virtuous Medicine in Practice

This chapter will focus on the actual clinical practice of medicine and how the virtues and theories discussed in the previous two sections are brought to bear on the problems faced by clinical practice. When we think of how we ought to live, this section ought to provide a functional understanding to augment the theoretical aspect discussed in the last two sections. To begin this inquiry, we will again start with the historical tradition of clinical practice and work our way towards the current modes of practice and the new problems they face. As a point of clarification, it is important to reiterate here that the reasons for understanding the historical traditions throughout this thesis are intimately tied to our current understanding of the practice. For practical thinking, we could easily say that in order to know where we are going we ought to know where we have been, but more than that, as MacIntyre and Cassell suggest, any given practice necessarily exists within a historical tradition and indeed within a historical moment. What defines a good doctor today is not necessarily what defined a good doctor fifty years ago and will not necessarily be what defines a good doctor fifty years in the future. This section focuses on practice that defines what a good doctor is right *now*; by initially revisiting the traditions that have led us to this point and the intricacies of medical practice, we can understand the aspects of practice that must change in order for physicians to be proficient in terms of the modern understanding of what proficiency means.

To this end, much has already been said about the historical tradition of clinical practice, namely that the historical tradition of medicine is best understood in terms of disease theory. Enough has been said about the actual theory and its limitations, but what has not been discussed are the benefits brought to clinical medicine by disease theory and how it has affected what historically defined a good doctor. Though we have seen how the theory is insufficient for virtuous medicine, historically speaking, "knowing about the disease was what counted" (Cassell 19). "The history of the era of scientific medicine really starts with the "discovery" of diseases by the French school of physicians in the 1830's, the first to provide clinicopathological correlation. The enormous success of modern medicine appears to rest completely on the combination of disease theory and science" (Cassell 19). As physicians searched for the cause of diseases, and indeed found a few, medicine discarded a monumental amount of guesswork by adopting the scientific method and applying it to the diagnosis and treatment of illness. "Clinicians had available to the them, for the first time, a science that generated objective knowledge of effective interventions based, where possible, on the results of unbiased experiments" (Daly 1). The development of this causal pathology ushered in a new era in medical practice where medical *science* became the authoritative force behind treatment.

With the authoritative force of medical science, however, came a very unique and specific understanding of the world born from disease theory. When physicians reflect on this type of science, they tend to see it as the "Science that provided the most important source of certainty in clinical decision making… the form of science that dominates medical training uses the equivalent of a microscopic lens, focusing on the

selected aspects of a phenomenon and excluding anything extraneous from the field of vision, seeing the cell rather than the human body from which it was extracted" (Daly 12). This is in fact a preliminary statement of the scientific perspective that continues to dominate medicine today, namely the perspective that has historically allowed no divergence:

> For medical science, the basis of all function is structure. Everything about the human condition will ultimately be explained in physicochemical terms— things like mind and soul, for example, are illusions or at best epiphenomena. Because of these postulates, medical science could not deal effectively with individuals, value-laden objects, things that change through time, or wholes that are greater that the sum of their parts. Since that list contains the characteristics of persons (be they patients or doctors), medical science could not handle persons— but disease lay clearly within its purview. The phenomenal success of medical science in showing how the body works in health and disease requires no comment (Cassell 18).

In addition to the specific way in which it views medical practice, this conception of medical science has also contributed to a very specific understanding of what makes the ideal physician. Simply put, intrinsic to the idea of medicine as a pure science is the conception of the physician as a pure scientist. Indeed, many physicians trained in this tradition consider themselves scientists first; their domain is one of medical research, ordered biological systems, and a rigid "objective" understanding of the world around them. As an example of this trend we can use an anecdote from the Department of Radiology of the Massachusetts General Hospital; in the 1950's a display case in this department displayed a stethoscope as an obsolete instrument. The case was meant to be symbolic of the rising belief that scientific medicine would eventually replace the subjective individualism that was perceived as a hindrance to medical practice (Groopman 101). In fact, today many researchers and some physicians still seek to rid

medicine of any ties to individualism or subjective decisions in hopes of creating an exact science of clinical care.

However, we saw in the last section that this conception of medicine has lead to a practice that does not give humans what humans are owed in their care. We now understand that the current practice of medicine ought to give more to the patient than a scientific diagnosis and treatment of the disease— medicine ought to alleviate suffering. Specifically, we now understand that "to be successful in treating the sick and alleviating suffering, doctors must know more about the sick person and the illness than just the name of the disease and the science that explains it" (Cassell *vii-xiv*). It becomes the task of the virtuous physician then to understand the new role that science must play in the virtuous practice of medicine.

To this end, we ought to alter our understanding of medicine as a science. It is true that, "science and medicine are inextricably bound, but the paradoxes and strains produced by believing they are the *same* led to a conception that could not last— that of the ideal physician as a scientist" (Cassell 17). We must understand that medicine is *not* a pure science. If we take a moment and reflect on what science actually is, we find that "science is based on a belief that it and its methods are value free— anything that happens in nature is neither good nor bad, it simply *is"* (Cassell 17). Medicine, however, is structured on a very rigid set of values: first do no harm, seek to provide care in the best interest of the patient, etc. Further, I believe that a physician would be hard pressed to find a suffering patient who does not attribute some connotation of good or bad to their ailment. So, since science and medicine are clearly not the same thing, we ought to

define what science is (The previous section was devoted entirely to the discussion of what *medicine* ought to be, so I will defer to Chapter 2 of this thesis for any reference to its nature.)

Firstly, I mentioned in the last section that physicians have a tendency to relegate anything not explicit to the realm of science to the realm of the spiritual, or to the *Art* of medicine, the art of medicine here suggesting a subjective and thus sloppy form of practice. I must now make it clear that this dichotomous way of thinking is intolerable. We cannot simply divide the practice of medicine into realms of science and everything else. If this argument has shown us anything, it is that medicine can only be understood as a practice characterized by *multiple* aspects of human life applied specifically to help those who suffer. As such, we must pay attention to each variable involved in the practice *simultaneously* to understand the proper application of each. To this end, I've already said that medicine must be understood as a "form of human encounter characterized by help" (Drane 21). At the heart of this encounter is a very specific relationship that exists between the physician and the patient; it is within this relationship that the various aspects of practice come together to form the true *practice* of medicine. So, to investigate the different variables that constitute medicine and understand the proper place of each within virtuous practice, we must obviously understand what each variable *is.*

For the sake of argument, we can break the *relationship* down into two specific dimensions, the physical and the human. Though it may seem like there is still a dichotomy that exists, I warn the reader to be wary of making that assumption in

reference to this argument. My initial disagreement is with dividing the whole practice of medicine between the scientific and the "artistic." My criticism is of those within the practice who argue for a *science* of clinical care and who delineate between the art and science of medicine by reference to a hierarchy of value as it pertains to what makes the best doctors. These are individuals who seek to eliminate the human element from the practice entirely. I am suggesting, on the other hand, that in order for medicine to be a virtuous practice it must incorporate *both* elements of science and humanism into the doctor-patient relationship by reference to the necessary virtues. The resulting synthesis will then yield the virtuous physician; the key to this understanding is according each dimension its proper place.

For the remainder of this thesis, the scientific dimension of this relationship will be known specifically as biomedical science. This is the science born from the development of disease theory and which has rightly been described as a "revolution" in medical and scientific understanding which "grants an intimacy with nature's workings, at a deep, molecular level, once unimaginable" (Howard Hughes Institute *vi*). For the sake of specificity, we can define biomedical science as the application of the physical sciences, especially the biological and physiological sciences, to the practice of medicine. Within this dimension of the doctor-patient relationship lays all knowledge about the function, structure, and care of the human body collectively possessed by physicians, researchers, and medical educators. This is the realm of diagnostic procedures, treatment, and any other knowledge that might be applied to the actual act of healing and the relief of bodily suffering. Biomedicine is, inarguably, a necessary part of medical practice,

without it there is no medicine. However, its current role in medical practice is given too much attention. Like disease theory, biomedicine does not account for the suffering of persons; I mean to suggest that it must be restrained to its appropriate place within medicine so that the care of the sick involves the complete alleviation of suffering.

Currently, the standard for medical care is synonymous with the standard of science and technology behind the care given. How "good" a modern physician is in the eyes of the medical institution is based on his or her ability to utilize science and technology to diagnose and treat illness. Where disease theory is concerned with the efficiency and accuracy of diagnosis and treatment of the disease, so the development of the physician has historically focused on the cultivation of similar values. At this point, it seems elementary to say that medical practice requires *more* than just science, but it seems fair to say that the "more" required for medicine to be virtuous is of a very specific type, namely a *humanistic* type. Even those working within the field of biomedical research understand this to be true. They suggest that, although there are priceless advances to be made in biomedical application, "today, humans themselves are the biological paradigm" (Howard Hughes Institute *viii*). To understand what this actually implies we ought to look at biological understanding as a whole. Biological investigation is seen in terms of increasing levels of complexity as understanding progresses. For humanity, this has led us to an interesting impasse where our increasingly complex view of human biological processes has collided with an ever-increasing need to understand what it means to be a person, as our discussion of personhood in Chapter 2 has shown. In fact, we have come to such an intricate understanding of the human condition that we are

now having to retreat slightly from the physical realm in order to better understand human existence, especially as it pertains to one of suffering. Even the biomedical researchers of the Howard Hughes Institute go so far as to say that "a more penetrating grasp of our biological identity will color our sense of ourselves as human beings." This is simply reiterating what we have been talking about all along, the need for a humanistic approach to medical practice that will augment our application of biomedical science.

To this end, we can now discuss the other dimension of the doctor-patient relationship, the human side. Much has already been said about this aspect of medical practice in Chapter 2, namely that an understanding of personhood and suffering is an absolute necessity for virtuous medicine. With this in mind, we can say that this dimension of practice is comprised of the socio-historic understanding of those involved. Put another way, "Because patients have personalities, character, virtues, vices, fears, thoughts, projects, and loves, these dimensions, too, have a place in the way they are treated by doctors" (Drane 22). For a practical discussion of this aspect in terms of the physician, "this dimension of the relationship involves physicians learning to be doctors— healers and professionals— as opposed to scientists. Walsh McDermott called this human dimension of the physician-patient relationship Samaritanism" (Cassell 17). For the practice of virtuous medicine, we can understand Samaritanism as the source of beneficence in practice; it is a term that instills a sense of intimacy between the actions of persons. In short, Samaritanism is the term that describes the manifestation of the various elements of personhood and virtue within medicine, specifically within the context of the doctor-patient relationship. Another way of thinking of Samaritanism is *as* virtue.

"Virtue, like *ethos,* refers to a lived personal dimension of morality" (Drane 154). Where the cultivation of the virtues is the lived *inner* reality, Samaritanism represents the lived *practiced* reality of the virtues within medicine. With this in mind, we can start to get a feel for the whole picture of the doctor-patient relationship and the practice of virtuous medicine.

Looking to practice, we can say that it is the combination of biomedical science and Samaritanism that creates the doctor-patient relationship, but *how* this combination is accomplished might prove a more fruitful inquiry. To augment this discussion, we ought to look back to previous sections. We can now understand these two dimensions of the doctor-patient relationship as the internal goods specific to the practice of medicine. Specifically, these two dimensions, biomedical science and Samaritanism, are the direct result of the pursuit of excellence within medicine. The application of biomedicine characterizes the excellence of the science of medicine to alleviate bodily suffering, where Samaritanism characterizes the excellence achieved by cultivating the virtues towards the same end. To clarify, we must return to the discussion concerning *practice* and internal goods as they are understood by MacIntyre.

We have already discussed MacIntyre's conception of a practice. Specifically, I have said that the key to understanding *practice* is as the achievement of excellence within a social role, the achievement coming in the form of internal goods. For medicine, we have said that it is specifically the alleviation of suffering that characterizes that excellence. To this we have now added the modes by which suffering might be alleviated, namely through biomedical science and Samaritanism. To bring the discussion full

circle, we ought to add that it is through the cultivation of the virtues and their application to the modes of alleviating suffering that the practice of virtuous medicine becomes a reality.

If we return briefly to the discussion of the virtues in the previous section we can answer how their application comes about in practice. I have already discussed each of the virtues in turn, but now when we look at how they apply directly to the doctor-patient relationship we can begin to see virtuous medicine in practice. For example, if we think of the application of biomedicine at the bedside, specifically its diagnostic and therapeutic application, we can see how benevolence ought to be understood as the pursuit to do no harm. Further, if physicians cultivate respect and compassion we can see how this would drive them to perfect their biomedical techniques so that benevolence might be served properly. In addition, we can see how the cultivation of truth makes the application of biomedical science possible; it is literally impossible to implement biomedicine at the bedside without disclosing the truth about what the doctor is physically doing to the patient. In regards to Samaritanism then we can say that the cultivation of the virtues is what augments the specific *human* qualities necessary for the doctor-patient relationship. With the cultivation of benevolence comes the desire to heal, with truth and respect comes a mutual understanding that allows the relationship to flourish, and with compassion comes understanding of the patient's suffering. In addition to all of this, we can say that it is the virtue of justice that ensures everyone has an opportunity to enter into this relationship when needed. In short, it seems fairly plain to see how the cultivation of the medical virtues will provide the *specific* qualities necessary

to promote the doctor patient relationship and how this relationship leads to the alleviation of suffering and will characterize the best modern physician.

Now, however, I would like to take this discussion to the macro-level so that we can address certain aspects of medicine as a whole that affect the way we understand virtuous medicine in practice. We have seen how medicine can be characterized as virtuous at the level of the patient through cultivating the virtues and the alleviation of suffering, but medicine does not exist as an isolated interaction between patient and physician. In fact, we know medicine to exist as an entire social institution, which this thesis has suggested is severely lacking in its moral obligation to human beings. Now we ought to look at what aspects of the practice as a whole are negligent and seek to find where our new understanding ought to be adopted to ensure the alleviation of suffering.

With this in mind, I would like to discuss a relatively new trend known as "evidence-based medicine" that seeks to advance the same beneficial principles brought to medicine with the advent of disease theory. "In the 70's," writes one proponent, "questions were being asked about the validity of using traditional clinical authority as the basis for clinical decision making, and there were no grounds for appeal except by reference to the very authority that was being questioned. One response was to make clinical care scientific by developing a new clinical science, additional to the science of biomedicine. This would provide clinicians with a secure foundation for their clinical task" (Daly 1). Evidence-based medicine seeks to create a "science" of clinical decision-making. Similar to the objectivity born from disease theory, this conception of medicine seeks to detach clinical decision making from the sole experience of the physician, which

it understands as subjective and thus limited. As an example of what this might look like, if an oncologist were debating between two possible treatments based on the toxicity of each, he would need a formula, algorithm, or evidence-based study in place to assess the success of each option based on the objective parameters of the case and the treatment options. Immediately we can see how this reliance on "objectivity" alone conflicts with the Samaritanism inherent to medicine, but we will put aside the obvious objections for now in hopes of keeping certain valuable aspects of this method that will allow for the attainment of the internal goods associated with the scientific dimension of practice.

First we ought to understand more about the theory and application of evidence-based medicine (EBM). The end goal of EBM was succinctly articulated by Dr. Gordon Guyatt of McMaster University as, "the application of scientific method in determining the optimal management of the individual patient" (Daly 6). The idea is to improve the consistency of clinical decisions by providing an objective ground upon which the physician might stand. The primary approach to this type of EBM is known as clinical epidemiology, which "focused on the application of quantitative methods to the empirical study of clinical practice," which simply means that it seeks to supply quantitative data to aid clinical decision-making (Daly 4). It is important to note here, that "the aim of clinical epidemiology was not to displace biomedicine or clinical skill in patient care but to develop an additional, explicit, and comprehensive science of the way in which biomedical knowledge is implemented at the bedside" (Daly 5). In terms of virtue theory, this is exactly what is needed. Any augmentation to the way biomedical science is implemented at the bedside can only mean improvements in patient outcomes, which is

the primary aim of the scientific dimension of care. However, a critical look at EBM will warn us that, "there is a need to view EBM as just one part of the strategy for improving decision making" (*Evidence Based Medicine: In its Place* 62). We must be cognizant of this point because there are those proponents of this theory that would try a hegemonic application of EBM to clinical practice, which would merely expedite the loss of the person from medicine. Other proponents of EBM, who do consider it only one part of decision-making, suggest that:

> "While 'good care' obviously needs guidelines and standards, they are not enough on their own to ensure good care. We may say that this performative kind of care is 'a caring for.' The moral dimension, however, refers to 'caring about.' We can *care for* people by following protocols, but to cope flexibly with the needs of the ill, we need to *care about* them in a more strictly moral sense. Management protocols provide rules that help us to care for. Our consciousness and compassion provide guides to caring about" (*Evidence Based Medicine: In its Place* 64).

This, obviously, is a reference to the link between biomedicine and Samaritanism. What is important here is the place of EBM *within* the context of virtue theory. Once again we see two aspects of patient care, the scientific and the human; EBM can offer us a better path towards decision making by providing objective evidence amid constant uncertainty. When we reflect on this idea in terms of *Magis*, we can understand EBM in a more comprehensive way. If we think of biomedical science as being inherently value free due to its objectivity, then EBM provides a concrete way of evaluating that objectivity based on the *best knowledge available*, thus representing a "better way" for the scientific dimension of practice. Similarly, when EBM can be used to provide quantitative data to support the application of Samaritanism to medicine, it provides a certain level of

standardization to a dimension of practice long thought to be subjectively unknowable. Before I go any farther in this discussion, however, I must reiterate so as to make it very clear that the goal of EBM is to apply quantitative data to clinical decisions in hopes of grounding that decision in an objective framework. Though this is not an inherently troublesome idea, because obviously any further evidence for Samaritanism and biomedical effectiveness can only help alleviate bodily suffering, it becomes problematic when it is applied in order to eliminate the human element of care and replace it with scientific objectivity. It must be understood that any discussion of EBM and its methods within this thesis should only be understood within the context of virtuous medicine, meaning that no application of EBM should take place without reference to the virtues and Samaritanism. For this reason, we will use the following definition for evidence-based medicine in order to understand the subsequent methodology in terms of Virtue Theory:

> "Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the thoughtful identification and compassionate use of individual patient' predicament, rights, and preferences in making clinical decisions about their care" (qtd. in *Evidence Based Medicine: In its Place* 2).

With this in mind, let us turn to the specific application of EBM to the clinical setting. "In order to focus on the clinical setting, clinical epidemiology drew on the methods of epidemiology and biostatistics to develop systematic ways of ensuring that the best clinical data are collected and accurately interpreted, leading to well-justified

treatment or management plans" (Daly 5). This essentially means that the focus of EBM is on the collection and compilation of quantitative data so that this data might be reapplied to patient management in the clinic. Though there are many methodologies that might be implemented to generate quantitative data in the field of biostatistics, I will focus on the primary methodology utilized by popular EBM, the randomized controlled trial.

The Randomized Controlled Trial (RCT) is "the research method seen as best able to generate firm scientific evidence of interventions in clinical practice… In its simplest form, patients are randomly assigned to a group receiving the treatment under investigation and to a control group receiving standard treatment, a placebo, or no treatment at all. If the two groups are initially the same, and then are treated in exactly the same way in all other respects, any difference in outcome must be attributable to the treatment" (Daly 5-6). RCT's represent the formal assessment of causal relationships based on scientific reasoning. I must say, however, that the randomized controlled trial is not necessarily what is utilized directly by the clinical physician.

By the early 1990's, RCT's were providing a solid basis for scientific evidence to clinicians who sought to practice EBM. However, "the proliferation of randomized controlled trials in the medical literature created a problem in even keeping up-to-date with the literature in a single area of practice" (Daly 6). Physicians simply could not disseminate the volume of evidence offered by such a large body of evidence. Though evidence from the vast library of trials could be collected and presented in a simplified form, the larger challenge was to create an overview of the evidence that could be

assimilated by clinicians, especially when different trials produced contradictory results (Daly 7). "What was needed next was to collect all the studies done in an area, to exclude any that did not meet quality criteria for excluding bias, and then to conduct meta-analysis, a statistical method for combining the results of the studies to produce an overall estimate of effectiveness or some other form of systematic review of the evidence" (Daly 7). This utilization of meta-analysis is what truly gave birth to the clinical application of RCT's. Through efforts such as the Cochrane Collaboration and the *Oxford Database of Perinatal Trials*, clinical physicians now have a referential body of scientifically scrutinized data that can be utilized to improve patient care at the bedside.

To demonstrate how this body of knowledge is specifically applied to the lives of persons and physicians, I think it will be beneficial to look at the results of certain RCT's that explicitly address the issues discussed in this thesis; this way we will be able to see exactly how randomized controlled trials and evidence-based medicine can be applied to the *practice* of Virtuous Medicine. Specifically, we will look at an evidence-based appraisal of Samaritanism in order to understand the relationship between biomedicine, the virtues, and clinical care. What we need to address are the specific changes that need to be incorporated in the practice of medicine. EBM offers one route to take that provides quantitative results for how well any changes being made are being implemented at the bedside. The following studies are devoted to discovering what aspects of clinical practice are beneficial to patient care. They suggest that physicians need to be more "patient-centered" in order to alleviate suffering. We can understand the

term “patient-centered” to be synonymous with our understanding of Samaritanism. In other words, being “patient-centered” implies that a doctor is developing character traits (virtues) that make him or her a better medical practitioner and then implementing those traits at the bedside (Samaritanism). Keeping this in mind, we can turn to our first look at RCT’s, which address the importance of patient adherence to treatment guidelines.

Patient adherence in clinical medicine is usually understood in terms of compliance. If a patient is noncompliant, which is a term used broadly across a wide range of patient tendencies, then they are considered hostile to management. In the following randomized controlled trials, researchers have been investigating the various factors that contribute to patient noncompliance in an attempt to develop a strategy to make physicians more effective healers. In one particular study, the author of the trial is an attending physician at the U.S. Veterans Hospital in Portland Oregon. The objective of the trial was to “identify certain strategies that can be used to reduce resistance and improve the odds of achieving positive clinical outcomes among noncompliant/resistant patients” (Butterworth 21). The study was based on clinical observations where the physician was investigating circumstances where actual clinical outcomes were affected by patient adherence to the physician’s interventions. The researchers concludes that“A worst-case scenario undermining positive clinical outcomes is one in which the provider is arguing for change while the patient argues against it” (Butterworth 21). The researcher suggests that enlisting certain strategies to improve patient adherence to interventions will ultimately improve the health outcome for the patient. In other words, by enlisting the patient in the process of their own care the researcher believes that the

physician can improve his or her effectiveness in the clinical setting. Indeed, "the evidence suggests that a level of participation in clinical reasoning, appropriate to the individual, contributes to the patient's sense of control. This may positively affect psychological well-being, physical recovery and satisfaction, and lead to patients accepting greater responsibility for their health (qtd. in Higgs 69). The conclusion of this trial is that a client-centered approach is the most important component of a health-coaching skill set. "Patients can ascertain whether you are truly attempting to understand their situation instead of merely manipulating them into change. Respecting each patient's autonomy, drawing out ambivalence about change, evoking change talk, and allowing the patient to develop and/or own the treatment plan greatly improve the odds of achieving positive clinical outcomes" (Butterworth 24).

This study is one example of how physicians might be able to assimilate the results of RCT's into their practice. However, it does not say very much about the specific strategies used to accomplish this integration in the clinical setting. Though this trial does tell us something about the need for Samaritanism in clinical treatment, I mean to use this example as a demonstration of how the information is presented to physicians who are seeking actual quantitative data to inform their clinical decisions. In short, I mean to demonstrate how some clinical trials are certainly better than others, this one being less than what physicians ought to expect from research science and evidence-based medicine.

In contrast to this study, we have numerous examples within the literature that provide a thorough scientific appraisal of clinical medicine. For example, the following

discussion of a clinical trial performed by Koe et. al suggests that there are numerous factors that affect patient satisfaction in the clinical setting. First, however, I must say several things about the nature of this trial. Patient satisfaction, though often thought of as a useless phrase employed by psychologists rather than a clinical term for medical practitioners, is a vital part of clinical medicine. We have spent the better part of this thesis discussing the place of the person within medicine. This necessarily means that the opinions and views of the patient, especially when they come to bear on clinical decisions, are completely vital to the alleviation of suffering.

The research, in this case, was conducted by the division of Gastroenterology at St Paul's hospital in Vancouver. The objective of the study was to "identify factors related to patient satisfaction with endoscopy and to determine if satisfaction after the procedure correlates with measurements at a later date" (Koe et al. 883). The trial was designed as a prospective cohort study set in a tertiary academic hospital. The patients used in the trial were patients within the hospital who were scheduled to receive endoscopy, colonoscopy, or both. The interventions of the trial were pre and post-procedural questionnaires administered on the day of the procedure and a third questionnaire administered one week later by phone or mail. The main outcome of these measurements was interpreted as satisfaction scores given to the physicians and other personnel involved with the procedure. The results of the study follow:

> A total of 261 patients were studied (53% men). The mean age was 55 +/- 14 years. A total of 226 patients (86.6%) were very satisfied with their endoscopy. Factors positively associated with satisfaction were as follow: doctor's personal manner, doctor's technical skill, nurse's personal manner, physical environment, and more time with the doctor discussing the procedure (odds ratio [OR] 3.00 [95% CI, 1.80-5.03]). Higher levels of pain or discomfort were associated with

> less satisfaction (OR 0.57 [95% CI, 0.36-0.90]). A total of 141 of 261 patients (54%) were reached for follow-up. These patients were less satisfied (rating dropped mean 0.35 points, P = .03) than those questioned sooner after the procedure and recalled experiencing more pain (rating increased mean 0.44 points, P = 0.01) (Koe et al. 890).

The researchers identified the limitation of the experiment as a single center for testing purposes. The study concludes by stating that they did indeed find statistically significant results that identified several factors influencing patient satisfaction, namely the doctor's personal manner, the doctor's technical skill, the nurse's personal manner, the physical environment, and more time discussing the procedure with the doctor. In terms of virtue theory, studies such as this can provide quantitative data to be applied directly to the patient by means of character development and Samaritanism. In this case, we can see that the need for the physician to develop the virtues of compassion, respect, benevolence, and truthfulness relate *directly* to how the patient will critically assess their ability as a physician. In other words, this is an example of how the results of a randomized control trial can affect the way both patients and physicians perceive care and the steps needed to make it better. It is important to note here that the reasons for this discussion of EBM are practical ones. We have spent the previous two chapters discussing the theory needed to establish the virtues in medical practice. Now, when we look at specific clinical examples based on quantitative data, we ought to see the need for that character development within the reality of the clinic.

To further understand the reality of clinical care, we can turn to Debra Roter, a professor of health policy and management at Johns Hopkins University, and Judith Hall, a professor of social psychology at Northeastern University; together they comprise the

most respected and renowned research team within the realm of evidence-based medicine today. Their research focuses on the human aspect of clinical care, specifically the various aspects of medical communication. Roter and Hall studied the effects of a doctor's bedside manner on successful diagnosis and treatment. "We tend to remember the extremes," Hall said, "the genius surgeon with an autistic bedside manner, or the kindly GP who is not terribly competent. But the good stuff goes together— good doctoring generally requires both. Good doctoring is a total package. This is because most of what doctors do is talk," Hall concluded, "and the communication piece is not separable from doing quality medicine. You need information to get at the diagnosis, and the best way to get information is by establishing a rapport with the patient. Competency is not separable from communication skills. It's not a tradeoff" (qtd in Groopman 19-20).

Roter and Hall go so far as to suggest that, "the way a doctor asks a question structures the patient's answers… if you know where you are going then close-ended questions are the most efficient. But if you are unsure of a diagnosis, then a close-ended question serves you ill, because it immediately, perhaps irrevocably, moves you along the wrong track" (qtd in Groopman 18). "The great advantage of open-ended questioning," suggests Dr. Jerome Groopman, "is that it maximizes the opportunity for a doctor to hear new information" (Groopman 18). "What does it take to succeed with open-ended questions?" Roter asks rhetorically. "The doctor has to make the patient feel that he is really interested in hearing what they have to say. And when a patient tells his story, the patient gives cues and clues to what the doctor may not be thinking about." The type of question a doctor asks is only half of a successful medical dialogue:

> The physician should respond to the patient's emotions. Most patients are gripped by fear and anxiety; some also carry a sense of shame about their disease. But a doctor gives more than psychological relief by responding empathetically to a patient. The patient does not want to appear stupid or waste the doctor's time, even if the doctor asks the right questions, the patient may not be forthcoming because of his emotional state. The goal of the physician is to get to the story, and to do so he has to understand the patient's emotions (qtd in Groopman 18).

Indeed, if we look towards certain RCT's conducted by Roter and Hall we find conclusions that "suggest that the emotional context of care is especially related to nonverbal communication and that emotion-related communication skills, including sending and receiving nonverbal messages and emotional self-awareness, are critical elements of high-quality care; it holds significance for the therapeutic relationship and influences important outcomes including satisfaction, adherence, and clinical outcomes of care" (Roter, Frankel 34). They have even gone so far as to test issues of gender on the doctor-patient relationship. They found that, "female physicians engaged in significantly more communication that can be considered patient-centered. They engaged in more active partnership behaviors, positive talk, psychosocial counseling, psychosocial question asking, and emotionally focused talk. Moreover, the patients of female physicians spoke more overall, disclosed more biomedical and psychosocial information, and made more positive statements to their physicians than did the patients of male physicians" (Roter and Hall 519).

Though perhaps not readily apparent, this discussion shows us how critical the development of the physician's character is. In chapter 2 we saw how the cultivation of the virtues is necessary to develop the proper understanding of the person who is a patient. This discussion of the research conducted by Roter, Hall, and other medical

researchers shows us how we ought to apply that cultivation to the practice of medicine. Hopefully this discussion has shed some light on how complex the doctor-patient relationship truly is. Simply put, there is no formulaic conception of such a relationship— there is no pure science to describe it. What science can offer, however, is insight into various dynamics within that relationship. Roter and Hall have suggested that the way a physician questions and understands their patients will influence their competency as doctors. The other researchers discussed above have other critiques of different aspects of the same relationship, whether it is the paternalistic aspect or the quality of care or the very gender of the physician. What this allows us to say conclusively is that *all aspects of personhood come to bear on the practice of medicine.* What we need is a way to bring those dimensions to bear on the practice in a positive manner, hence the cultivation of the virtues and their application through Samaritanism.

With this in mind, I would like to briefly discuss the education of modern physicians. Throughout this thesis I have been arguing for the character development of the physician so that we might improve the morality of the modern practice. To this end, I believe we ought to look towards what is currently being done to educate physicians in the way of character development. James Drane, while researching the place of ethics in medical training and education, came across a committee report on the place of ethics training in modern medical schools. The report states:

> "Before presenting our recommendation for a basic curriculum, we want to make explicit certain beliefs we hold about the teaching of medical ethics. First of all, we believe that the basic moral character of medical students has been formed by the time they enter medical school. A medical ethics curriculum is designed not to improve the moral character of future physicians, but to provide those of sound moral character with

the intellectual tools and interactional skills to give that moral character its best behavioral expression" (Drane 3-4).

In short, this report suggests that proper candidate selection is enough to ensure the moral nature of future physicians, which, as an undergraduate student intent on medical school, I can assure the reader is not the case. In fact, I contend that the vast majority of undergraduate students have never explicitly asked themselves questions about *Magis* or considered the explicit development of their character in a vocation-specific way.

This critique on character development in medicine, however, is not all together accurate. Though it is true that medical schools provide no specific curriculum for character development within an ethical framework, once in the clinical setting the aspiring physicians are being educated by practiced physicians who simply demand character development towards a moral practice of medicine. In fact, Dr. Groopman, who I have cited throughout the argument, wrote an entire book based on the practical application of character in medicine, which was inspired by his students who were lacking in this area. Specifically, he "concluded that these very bright and very affable medical students, interns, and residents all too often failed to question cogently or listen carefully or observe keenly. They were not thinking deeply about their patients' problems. Something was profoundly wrong with the way they were learning to solve clinical puzzles and care for people" (Groopman 4). Dr. Groopman suggests that great physicians achieve competence in remarkably similar ways. Specifically, while reflecting on the way doctor's think and treat the sick, he concludes that "they recognize and remember their mistakes and misjudgments, and incorporate those memories into

their thinking" (Groopman 21). This implies something very specific about the character development of the best physicians, namely that it occurs within the practice of medicine, as opposed to within medical education, and also that it is completely dependent on experience. Dr. Groopman suggests that, "clinical intuition is a complex sense that becomes refined over years and years of practice, of listening to literally thousands of patients' stories, examining thousands of people, and most important, remembering when you were wrong" (Groopman 20). This is the final critical piece of character development as it pertains to the virtues; the realization that medicine is a practice that requires experience.

As such, I would like to take a moment to discuss what is currently being done toward the development of character *within* the practice of medicine. Aside from individual practicing physicians, such as Dr. Groopman and Dr. Cassell, who seek to educate their students in a way that demands character development, there is also an overall trend in medicine towards this same end; the numerous authors, ethicists, doctors, and researchers I have cited throughout this thesis are evidence of this if nothing else. This trend in modern medicine is seeking to train physicians as doctor— healers who have their patients' best interest at heart. An example of this is the Robert Wood Johnson Clinical Scholars Program. To answer the growing medical responsibility for both social and physical functioning of patients, this program has instructed nearly 800 scholar-physicians at 14 sites around the U.S. in clinical treatment of patients as persons and recognizing the responsibility of medicine as a social practice (Daly 22). Though throughout this thesis I have enumerated the various problems inherent to modern

medicine, I must now point out that the trends *are* changing. The goal of this thesis is to explain the way they *ought* to change.

If we look at what has been said thus far, we find that we have a specific conception of what ought to change in order to have a virtuous practice of medicine. Specifically, we understand that our current mode of a rule-based practice cannot bear the full weight of right and wrong. We understand that we ought to attend to the virtues *first* in order to have individuals capable of responding to the complex demands made on moral actors. In addition to this, we understand something about the nature of moral actors, specifically that they necessarily find themselves within a world comprised of practices and that moral actors necessarily exist *within* practices. Our understanding of a practice then is characterized by the attainment of goods internal to that practice, those being the achievements characterized by the pursuit of excellence within the practice. For medicine, we came to understand that the goods internal to medicine are intimately tied to the function of medicine, namely the treatment of sick persons and the alleviation of suffering. We came to see that the practice of medicine is morally negligent because of its reliance on outdated theories and its adherence to an idea of practice that does not give humans what humans are owed. We then endeavored to understand the virtues and how their application to the current practice of medicine might make it a moral practice again by examining the specific dimensions of the doctor-patient relationship that will allow for their integration into the practice. To all of this I must now add one final suggestion.

Dr. Groopman, in his book How Doctor's Think, makes several references to one of the most common mistakes made by practicing clinicians, which he calls the "availability error" (Groopman 188). The availability error is a cognitive error made in problem solving. In medicine, it is where the physician allows what is most readily available in the mind, meaning past cases, to color his thinking about a new case that presents with similarities. This is a not-so-obvious error in medicine because often it causes the physician to miss important differences and arrive at an incorrect diagnosis; the error is not usually discovered until some aspect of the case changes and a reevaluation of thinking becomes necessary. In some cases this can be a simple fix by making the correct diagnosis and redirecting treatment to correct the problem. In other cases, however, missing the diagnosis once is all it may take. For this reason, I want to make one caveat to the application of the virtues to clinical medicine. While I do believe that through the application of the virtues we might create a practice of medicine that can alleviate suffering, I must warn about the most readily available error in this mode of thinking.

James Drane, in his pursuit of understanding the medical virtues, encountered one Dr. Minkowski who is considered a champion of the necessary independence of physician-based decision-making similar to what I have argued for in this thesis. Robert M. Veatch, a medical ethicist, went to great lengths to criticize doctors like Minkowski. His argument against these physicians is that, "they are dangerous precisely because of their convictions of righteousness. Because they think they know what is right, they suffer from hubris and other forms of blindness, which keep them from seeing and

considering the very different value framework of patients. Therefore, they tend more frequently to do the wrong thing than the right" (Drane 9). This is the availability error of virtuous medicine. If doctors begin to reference their own character as the sole basis for medical decisions and action, then they are making an error of hubris, which will inevitably meet with harsh consequences, for either themselves or the patient. What this means for virtuous medicine is that we must be very cognizant of this availability error. Simply put, we have more to reference in medicine than the character of the physician, we have seen many examples of these alternatives. What we ought to rely on is the character of the physician to be discerning. Dr. Groopman suggests that the availability error is an avoidable one so long as we do not constrain our thinking to what is most readily available. He suggests that if we remain vigilant, and apply all that we know to solving each new problem within medicine or morality, we can achieve nothing short of *greatness.* Greatness, for the modern physician, *can* be understood as the end of suffering, but only if we are willing to accept the proper place of *persons* within medicine. We must always remember, *"bodies do not suffer, persons do"* (Cassell *v*).

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