

Essay | *Francis O. Walker, MD*

Cultivating simple virtues in medicine

We have all marveled at the gifts of talented clinicians at work, individuals who can put troubled patients at ease with a few simple words or make a complex diagnosis at a glance. Understanding how they acquired excellence and how to pass it on to others, however, poses a challenge.

The timeless inquiry into human excellence constitutes the branch of philosophy known as virtue ethics.¹ Virtue ethics identifies the individual as a central moral agent and characterizes those dispositions that predispose to right or excellent actions as virtues, and those that predispose to wrong or poor actions as vices. Aristotle used physicians—as well as ship captains—as one of his central models for a virtuous person.¹ Both make decisions based on complex and sometimes conflicting observations, and both exemplify the value of virtues such as courage, judgment, fidelity, and prudence. Physicians are well suited to the study of virtue ethics because clinical care provides them an unadulterated view of human virtues and vices, ready familiarity with the language people use to describe them, and direct experience with their consequences.

So how do we learn excellence? The great medical virtues—compassion, fidelity (trust), justice, and integrity—develop gradually and frequently build on simpler virtues such as tact, self-awareness, good humor, reverence, and simplicity. These simpler virtues are less celebrated and often overlooked.

Tact. It may seem odd to consider tact a virtue worthy of mention in that it can neither save a life nor advance technology. If it is taught, it is never taught formally. Highlighting its presence in a colleague might raise suspicions that it is being mentioned in lieu of other, more tangible, capabilities.

Tact can be defined as the ability in conversation to say and leave unsaid just the right things. Tact helps protect patients from excessive or needless exposure. Most of us remember as medical students how awkward it was to ask personal questions of our first patients, phrasing them too vaguely or too explicitly. In return, most patients, recognizing the clumsiness of our attempts, would reply with tolerant patience and perhaps more candor than we wished. Through trial and error, we learned how to improve our discretion in asking and handling the responses.

Sometimes tactfulness opens the door to something more from patients who may be ready to disclose the unexpected. When this happens, it may startle both the physician and the patient. If so, silence often follows. Fortunately most patients interpret this as acceptance and are grateful. Such encounters teach the value of silence and the therapeutic impact of acceptance. Patients struggling with the weight of the world elevate those willing to momentarily take up their burden to almost heroic status. But, despite such endorsement, alleviating patient burdens in this way is a human, not Herculean, task; one that follows a path from tact toward compassion.

Self-awareness. Inscribed in stone, over the entrance to the oracle at Delphi, is the enigmatic command “Know Thyself.” Self-awareness, the ability to examine one’s motivation and behavior, can be considered a virtue for physicians. This requires a recall of one’s wants and emotional state when decisions were made. We act in accordance with our will, emotions, habit, and reason, and given the quickness with which most clinical decisions are made, it would be naive to assume that reason is the prime mover.

Assessing the influence of intuitive factors in decision making requires self-awareness skills that are not part of the traditional medical curriculum. One approach involves reflection. Increasingly students are given formal exercises in reflection, such as writing essays about the human dimensions of clinical encounters. By tapping our own reflexes or listening to our hearts with a stethoscope, we hone our knowledge of the human body; by examining our own thoughts and moods, it seems reasonable that we hone a similar appreciation of the human experience.

Good role models enhance insight into bias by disclosing to students on rounds about the temptations and tensions that color their shared patient encounters. Such revelations give trainees permission to identify and name similar, and perhaps previously unrecognized, forces within themselves. The ability to name and to compartmentalize bias or self-interest promotes tolerance and humility.

A physician who can see herself for who she is is better able to see patients for who they are. Such knowledge involves accepting their weaknesses and advising them about the potential costs of their

vices. It implies recognizing strengths as well. A virtuous physician is one who knows when to recommend abstinence and when to dispense condoms. Similarly, knowing when others need to be consulted and when to trust one's own judgment is an essential skill in clinical practice.

Simplicity. It is difficult to keep things simple in medicine. Knowledge is expanding and the field complex. It is tempting to equate helping patients with the amount of information provided, but simple observation shows that the internet's endless resources rarely substitute for an expert's tailored explanation. When students answer questions on rounds, they are often graded on their ability to demonstrate their grasp of complexity. At the bedside, patients grade us on a different scale. They value information that can be simply shared with friends and family.

Simplicity extends beyond styles of communication to styles of practice. Medicine offers numerous options for intervention. It is the wise physician who knows when enough has been said or done. Simplicity counterbalances therapeutic zeal. It leads naturally to temperance, the virtue of diagnostic and therapeutic parsimony.¹

Simplicity leads also to humility. Physicians enamored with their reflections in the eyes of grateful patients overlook the fact that most accomplishments are little more than replays of predecessor's achievements. Those with the simplest appreciation of their worth see themselves as creatures of good habits, attempting to repeat the successes, and avoid the failures, of the past.

Good humor. Good humor rarely gets a line on evaluation or feedback forms or serves as a topic in the medical literature. Yet it is recognized as a virtue, albeit, one that is hard to define. At its heart is a perceptive ability to size up a situation and its implications. Clinical encounters provide a rich canvas from which to work. Trainees are often surprised to find that patients often respond to humor, even in discussions of the most serious consequence.

Good humor is more successful in promoting an interview than reserved disinterest, and if for no other reason, it is a bedside skill worth acquiring. Like any skill, good humor is learned by observing others, by adapting effective strategies, and by trial and error.

Language, used with tact, is how we communicate reason to our patients, and good humor, used with prudence, is how we communicate hope. Humor identifies themes shared in common between physician and patient and in doing so combats the social isolation of disease. Seeing a physician's good humor inspires confidence that a situation is neither novel nor unmanageable. In conditions fraught with peril—as many diseases are—being able to identify potential respites, even if remote, can help patients look to a future that is not unbearably stark. By alleviating

undue burdens of disease, good humor can help patients focus on practical issues of living.

Reverence. In its classic sense, reverence refers to paying proper respect to the gods; restated it can also be an understanding of what it means to be human and the distance this state is from the divine. Woodruff² suggests, less theistically, that it is the ability to experience awe and respect for that which is profound and yet which we do not or cannot know. Surely it is an integral part of a profession that deals with death, life, birth, suffering, and survival.

The enduring role of reverence in medicine can be seen in the Hippocratic Oath, which is still widely recited in medical schools today. The oath evokes reverence because it has captured a sense of respect and awe for human life, for confidentiality and trust at the bedside, and for the fact that we can alleviate suffering and teach others to do likewise.

Reverence is an antidote to hubris (thinking one is like unto god) and arrogance, vices some would say are endemic in the profession. Reverence involves the recognition of human excellence but distinguishes it from the ineffable concept of perfection. As such, it leads to humility and self-effacement. Of note, Woodruff points out that the opposite of reverence is not irreverence as we currently use the term.² The true opposites of reverence are shallowness, crudity, and brutality.

Courage. Courage is recognized as a major virtue in medicine but of late it has been given short shrift.^{1,2} Courage is a military virtue, one that focuses on the individual; some see this as a threat to cooperativeness and thoughtfulness. But understood correctly, courage is essential to the development of the other virtues. Without them, courage is aimless; but without courage, all other virtues are at risk. It took the courage of physicians dedicated to those with HIV to spearhead standards of care over the resistance of uninformed colleagues. It took the courage of physicians who care for the disabled to lead efforts to provide access for the handicapped. It takes courage for physicians to deal with child abuse, to refrain from extending life in those who choose otherwise, to restrict driving privileges in the impaired, to ask for help, to work out compromises in interdisciplinary care and to admit errors. It takes courage to stand up for professionalism.

Courage is never learned in a vacuum. It is instilled by the society of medicine by witnessing and emulating courageous actions of one's peers and mentors. The responsibility of those who care for the sick and infirm is that they also must be willing to take up their cause when society or the social systems of medicine fail to meet their needs.

Prudence. The product of prudence, clinical judgment, is prized in physicians. But the virtue of prudence needs to be understood in its classic sense. It is an intellectual virtue that involves the capacity or

disposition to assess situations, in the context of all the virtues, and to select the right balance between means and good ends.¹ Prudence, as Aquinas points out, governs the other virtues. A complex virtue, prudence involves intellectual and rational elements blended with humane consideration.

Clinical encounters typically involve calls to multiple virtues—compassion, justice, courage, gentleness, or tolerance for example—and it is not uncommon for these to pull in different directions. For example, it can be difficult to know if it would be better to scold a noncompliant patient or to be empathetic. Some situations require courage more than tact, others justice more than compassion. Prudence, a meta-virtue, helps to steer the right course.

One of the values of prudence is that it requires cultivation of multiple virtues, not just those that come easily to an individual. When decisions lead to undesirable outcomes, it can sometimes be a clue of an excess or deficit of a virtuous tendency. An example might be the physician who over-prescribes narcotics for non-malignant conditions, signaling either that she empathizes too strongly with minor discomfort in her patients or that she lacks courage to refuse inappropriate requests.

The English proverb that describes hell as paved

with good intentions recognizes the danger of heeding the call of an unbalanced tendency to do a certain kind of good. The recipe for right action is not determined solely by a single virtue but rather by all the virtues, great and small.

Summary. Any number of additional virtues could be included in a discussion of the practice of medicine; and, to some extent, that is the point of this essay. It may be difficult to teach the great medical virtues of compassion, fidelity to trust, or clinical judgment. However, almost every case allows us to teach our trainees something about tact, good humor, self-awareness, or simplicity. We are privileged to see the virtues in action every day, modeled by patients, families, and even trainees. We are all students of excellence. To give lessons in what is excellent, we need only to recognize virtue when we see it, point it out to those who would benefit, and marvel at its effects.

References

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2. Woodruff P. Reverence: Renewing a forgotten virtue. Oxford: Oxford University Press; 2001.