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Virtues in healthcare: contributions from Pellegrino and Thomasma

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Abstract

This article presents an analysis of Pellegrino and Thomasma's proposal to use virtues as a bioethical framework, especially in clinical bioethics. The authors suggest that a view purely based on principles or duties is insufficient, especially in healthcare. Good health professionals have certain virtues that empower and impel them to follow ethical principles and be better people, which invariably helps them achieve the goals of medicine. Thus, an approach that considers the convergence between virtues and principles moves away from an instrumentalized view of medicine and changes the emphasis from ethical analysis to the professional and how their character and conduct contribute to the interests of the patient, whether determined by medicine or by their personal aspirations and inner values.

Keywords: Bioethics. Delivery of health care. Virtues.

Resumo

Virtudes no cuidado sanitário: contribuições de Pellegrino e Thomasma

Este artigo apresenta uma análise da proposta de Pellegrino e Thomasma de utilização das virtudes como referencial bioético, especialmente na bioética clínica. Os autores sugerem que uma visão puramente baseada em princípios ou deveres é insuficiente, principalmente no cuidado sanitário. O bom profissional de saúde é detentor de determinadas virtudes que o empoderam e o impelem a seguir princípios éticos e ser uma pessoa melhor, o que, invariavelmente, o ajuda a alcançar os bens da medicina. Assim, uma abordagem que considere a convergência entre virtudes e princípios afasta uma visão instrumentalizada da medicina e altera a ênfase da análise ética para o profissional e como seu caráter e suas condutas contribuem para os interesses do paciente, sejam aqueles determinados pela medicina ou por suas aspirações pessoais e valores internos.

Palavras-chave: Bioética. Atenção à Saúde. Virtudes.

Resumen

Virtudes en el cuidado sanitario: aportes de Pellegrino y Thomasma

Este artículo presenta un análisis de la propuesta de Pellegrino y Thomasma de utilizar las virtudes como referencia bioética, especialmente en la bioética clínica. Los autores sugieren que una visión puramente basada en principios o deberes es insuficiente, especialmente en el cuidado sanitario. El buen profesional de la salud posee ciertas virtudes que lo empoderan y lo impulsan a seguir principios éticos y a ser una persona mejor, lo que, invariablemente, lo ayuda a alcanzar los bienes de la medicina. Así, un enfoque que considere la convergencia entre virtudes y principios impide una visión instrumentalizada de la medicina y cambia el énfasis del análisis ético hacia el profesional y a cómo su carácter y sus conductas contribuyen a los intereses del paciente, ya sean estos determinados por la medicina o por sus aspiraciones personales y valores internos.

Palabras clave: Bioética. Atención a la salud. Virtudes.

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Bioethics as it is understood nowadays began in the 1970s, with the publication *Bioethics: bridge to the future* [1], by Van Rensselaer Potter. Potter's original proposal presented a new concern for human life and the environment, in which ethics, values and life sciences were integrated. His bioethics was not restricted to biomedical issues, but it was broad, encompassing other areas of life, such as the impacts of technological development and biodiversity.

Nevertheless, with the publication of the *Belmont Report* [2] and especially of the 1979 publication *Principles of Biomedical Ethics* [3], bioethics adopted an approach focused on ethics and medical practice and expanded throughout the countries of the so-called global North, which were colonizers and considered developed. Despite being highly criticized in countries in the global South, the principle-based approach known as principlist bioethics remains widely adopted, especially in clinical and healthcare contexts.

In the same period as the emergence of bioethics, the 1970s, many new ideas emerged regarding virtues and attempts to revive an aretaic vision as a counterpoint to the dominant models since the onset of modernity—consequentialism and deontology. Over the following decades, several philosophers and ethicists would contribute significantly to the construction of an ethics whose focus would be the agent, their character and motivations, and which considered duty and results second-tier.

Consequently, many professionals from other areas started showing an increasing interest in the implementation of approaches based on virtue to their respective fields. In the field of medical ethics, physician Edmund Pellegrino and philosopher David Thomasma published, jointly and separately, works of great importance for the study of social, cultural, and moral phenomena that influence the practice of medicine. *Philosophical basis of medical practice* [4], *For the well-being of the patient* [5], *Virtues in medical practice* [6] and *Christian virtues in medical practice* [7] are a part of an ongoing project to develop a coherent moral philosophy applicable to medicine.

The discussion proposed by Pellegrino and Thomasma, despite being prone to current criticisms, reveals a concern in relation to the predetermined view of medicine and one of its the sub-areas known as clinical bioethics, which stems from the 1990s—the start of the revival of the original concept of bioethics. The use of virtues as a bioethical theoretical framework demonstrates a concern that transcends the classical perceptions of the physician-patient relationship and the instrumentalization of medicine as opposed to actions based on amoral values that are distant from the individual, their personality and desires.

The virtues alternative

Pellegrino and Thomasma [6] understand that, as much as there are several theories of virtue, those that came after Aristotle contributed nothing or very little to the theory as a whole. In this sense, many contemporary philosophers have revived ancient virtues to elaborate what they currently call virtue ethics. The authors had already noted that Aristotle often used medicine as a model or example to explain his method and ethics. This, according to them, suggests an important relationship between health and the virtues that health professionals should possess [4].

Alasdair MacIntyre [8] proposed that virtues should be understood as acquired dispositions or qualities, distinguished by the following characteristics: 1) they are necessary for humans to obtain the good comprised in common practice; 2) they sustain common identities or communities through which individuals can seek good for their entire lives; and 3) they sustain the traditions that provide the necessary historical context to individual practices and lives.

Hursthouse [9,10] developed the idea of a hypothetical virtuous individual whose conduct would be the mold for others. Anscombe [11] and Foot [12,13] adopted a functionalist view by rejecting the criterion of a stronger moral rule and identifying virtues based on what is conducive to the individual and society's ability to recognize good. Swanton [14], in turn, complemented it with a pluralistic view of the virtues, according to which the goal of virtue and a conduct corresponding to this objective define virtue itself. Slote [15-17], more recently, has developed a kind of care ethic, which gives greater importance to the good motivations that prompt the individual to act.

In any case, it is possible to perceive that the many virtue ethics provide a theoretical apparatus embodied in proposing an alternative to the dominant ethical models—deontology and consequentialism—safeguarding the focus on the agent and their character, by prioritizing qualities or excellence to the detriment of duty or results. Their prescriptions do not have, and do not intend to have, the binding weight that their contestants do but provide an expansion of the determining factors of the rectitude of an action, encompassing elements that are inseparable from human life and that are forgotten by the others.

In this sense, a criterion for correctness of action, especially in healthcare, cannot be guaranteed simply by a purely principle-based, duty-oriented or results-based approach. Even the most morally elevated principles are not able to ward off a bad character or motivations or to guard the patient against a proud, greedy professional or someone that is simply unconcerned with the patient's well-being. Moreover, the view that it is better for our caregivers to be more dedicated to some ideal of the collective good than to individualistic motivations—that is, for their professional inclinations to be more strongly based on their qualities of character and motivations than on the desire for fame, money, or prosperity—seems acceptable [6].

The correlation between virtues and principles

Far from blindly defending the infallibility of an ethical system based solely on virtues, it is certain that, like other ethical and moral models, this one also has its limitations. Perhaps the most relevant is the problem of the wide variety of definitions of virtues and the different characteristics or qualities that are considered virtues in different philosophical systems.

It is not difficult to imagine, therefore, that overcoming this problem means reconciling visions that were originally opposed. MacIntyre has already adjectivated such a task as *immeasurable* and *unyielding* [8] because, in a plural society, there is a great variety of moral goods, which are valued depending on the community and examination.

However, even with the eventual agreement on the definition of certain goods, it is possible to observe a logic in virtue ethics. Morally accepted conduct is performed by the virtuous individual. Therefore, the virtuous individual is the one who performs morally good behaviors. This cyclical logic is fully acceptable when the notion or definition of a certain good is common and accepted by the majority.

In a practical area like bioethics, it is urgent to find the point of intersection that ends this circularity between virtues and the virtuous individual. This connection, which seems to have been forgotten over time, is found in habit and choice, that is, in the individual's search for virtues, both in their private and professional life [6].

On the other hand, when we are faced with a dissonance between values or between what is considered good is what is not, further justification is needed regarding the quality of character or conduct that must be desired in order to configure a virtue. In this sense, the answer that seems to be taken by most philosophies is to use principles as beacons of ethics.

In general, a principle is an affirmation of a fundamental and universal moral truth, which is also expressed in action guides. Thus, the principle derives from the consideration of moral action, from its most fundamental aspects. A principle is not morally meritorious because it is respected by the virtuous person. In fact, we respect the virtuous person because we know that they are someone in whom we can trust and that will practice the virtue in question with a diligence that seeks perfection [6].

The logic here is that principles function as general or even universal guides for conduct. They may derive from fundamental postulates or institutions that have been accepted by the majority or even have the *prima facie* charcter of moral truths, meaning that they must be respected for their own sake—unless there is a very compelling reason to do the opposite [6].

Just like the principles of a certain area or field of study should guide the qualities of character that will be considered virtues, the virtues should guide the principles that will be valid or useful to support a certain professional performance or even towards weighing a conflict between principles in a practical situation.

In any case, the idea defended here is that virtues and principles must act together because they foster an excellency of character, which enables the agent to figure out the best interpretation of what to do and how to act to achieve the specific ends to which he has agreed to. This is in line with the previous idea, especially when applying the discussion to healthcare.

However, it cannot be disregarded that, especially since the beginning of the twenty-first century, and especially in nations of the global South, there has been strong retaliation against that which became known as principlism in bioethics. The four principles proposed by Beauchamp and Childress [3]—autonomy, justice, beneficence and non-maleficence–were and still are targets of several criticisms: for their very abstract nature, the excessive mathematization of its use in moral judgments and even its decoupling from the concrete human particularities of moral choice.

There is also the common accusation that these principles are dominated by a white, male, heteronormative moral psychology from the nations of the global North–the United States and Western Europe. This is not necessarily to say that these principles are useless or should be completely disregarded, but that tools that best evaluate moral acts should be sought based on the values of the communities in which certain moral agents are connected to.

Thus, an alternative to the principle-based system can draw from the source of virtue ethics, in the sense that it places greater emphasis on people, agents, and circumstances, regardless of the consequences or the formality of the rules. The challenge here is not to let these alternatives fall into subjectivism or exacerbated emotivism.

Virtues in healthcare

In a more contemporary period, Beauchamp and Childress [3] connected virtue, rule, and principle through motivation. Being virtuous does not only mean being willing to bring about good things but also desiring what is good. However, they do not explain what would be good in a concrete way. Nevertheless, the authors propose that every principle corresponds to a virtue. The principle of respect for autonomy is correlated to the virtue of respect. Non-maleficence is connected to the virtue of non-malevolence. Beneficence, benevolence. And justice remains justice. However, Pellegrino and Thomasma [6] note that this correspondence consists simply in converting the action guides into subjective states and renaming them, without establishing an essential difference between them. Beauchamp and Childress [3] admit that three of the four cardinal virtues–prudence, courage and temperance—do not fit their bioethical model.

For Pellegrino and Thomasma [6], the good professional, in any area, is the one who achieves the goals of the profession with the highest possible quality. In healthcare, this evaluation also involves a moral component, since the health professional's conduct must be in accordance with the patient's interests, whether those determined by medicine or their internal values and aspirations. To achieve these ends, certain character qualities are necessary, virtues that the health professional must possess and develop throughout their practice. In this article, seven of the virtues proposed by the authors were highlighted, namely: fidelity to trust, compassion, prudence, justice, fortitude, temperance, and integrity.

Fidelity to trust

Trust is extremely relevant in a state of vulnerability and dependence on the goodwill of the motivations of others, especially in the context of illness, when we are in need of help, healing and justice. To Baier [18] it would be leaning on others, in their competence and willingness to care instead of hurting. This is a virtue of great importance in the clinical sphere, as the very existence of bioethics shows that trust in the field of healthcare has failed. We need bioethicists to study social and professional relationships, establish and reinforce limits, improve practices, and criticize habits that no longer match what is expected. This implies that, at the very least, the relationships of trust between patients and health professionals are generally strained. There is, therefore, a relationship of hyposufficiency *versus* hypersufficiency, linked to a specific situation.

Fidelity to trust is, therefore, a virtue of the one who is trusted–which is the health professional in the healthcare field [6]. As a virtue, it shifts the focus of moral analysis to the agent, or the responsible for deserving and gaining the trust of their patients through the development of their character and professionalization, as well as faithful attitudes. It enables the exercise of discretionary latitude, which in turn improves the chances of reaching the goals of medicine, safeguarding due respect for the patient with regard to obtaining adequate information about their health status and the possibilities of treatment. If well adjusted, fidelity to trust can remove, or at least reduce, the need for deontological alternatives in the patient-physician relationship, such as contracts, intermediaries and ombudsman [6].

Compassion

In the context of healthcare, compassion is the quality that assembles the cognitive aspect of healing so that it fits into each patient's unique perspective. It is related to understanding, as it requires from its possessor the willingness to see, feel and experience the tribulations of the disease that affects the patient. Pellegrino and Thomasma [6] define compassion as a medical virtue that has an intellectual component–the habitual willingness to access and understand the uniqueness of the dilemmas of how the disease manifests itself in a given patient—and a moral component—because, without sharing the patient's specific characteristics, the professional could violate their values and feel discouraged in relation to the patient or their disease.

In this sense, compassion consists of helping the patient weigh their understanding of what is good and their grasp of medicine. This requires a certain level of discernment regarding the patient's values and dilemmas. Moreover, compassion must not be confused with other falsely correlated feelings, such as mercy, sympathy, empathy, and pity since each of these feelings lacks one or more specific elements of compassion, such as experimentation, approximation to the patient's pain [19] and the sharing of emotional responses to suffering [20]. Fundamentally, compassion is shown to be very similar to friendship, with the added competence and technical and scientific knowledge that the health professional has access to, unlike the personal friend [6].

Prudence

Prudence has a long history of great importance among the scholars of the virtues, to the point of being commonly regarded as the master virtue [6,7], the connection between moral and intellectual life. It concerns the ability to discern the most appropriate means to achieve certain goods in specific circumstances. Prudence configures the other virtues, since they are dispositions that must be justified in concrete acts—which will be guided by good moral choices. It is the glue that unifies technical competence and moral judgment, as well as being the key tool to counterbalance the available means, the therapeutic possibilities and the eventual effective results of the health professional's performance—elements that will never be the same for different patients [6].

That way, prudence plays an essential role, not only in life, but also in healthcare. It is the virtue that enables one to decide which other virtues will be important for their professional practice. It is the virtue that guides and shapes the other ones. Regarding practical cases, it is the indispensable virtue. To be a virtuous professional is, essentially, to be prudent. The prudent professional is the most apt to achieve the other virtues and, consequently, reach the goals of medicine.

Justice

In its most fundamental conception, justice means giving everyone what is their due. In the role of virtue, Pellegrino and Thomasma [6] understand that justice must be based on love for others; therefore, the authors refrain from choosing a specific view of justice–commutative, distributive, redistributive, general, or modular. All are applicable to different situations and/or at different stages of the same health case. Healthcare is a way of committing oneself to the good of others, which requires justice as a moral obligation, a notion that is also of a collective nature, since it demands special concern for those in pain, for the poor, the oppressed and the deviant.

Thus, justice does not concern only the distribution of goods or the respect for contracts, but it involves a comprehensive way of seeing and treating others [21], especially the vulnerable. Pellegrino and Thomasma [6] assigned an essential role to justice as a bioethical principle as a way of resolving conflicts between principles. By definition, being fair is promoting good, not causing harm, and respecting the patient's autonomy. However, in a public health reality in which the scarcity of resources predominates, justice as a virtue—not just as a principle—mediated by prudence, is essential to solve practical problems, as in cases in which the excess of autonomy or beneficence of a patient entails harming other patients [6].

Fortitude

Fortitude represents moral courage, the imposition of a sacrifice for the greater good; it is the choice to act well, in spite of all the possible undesirable consequences, and the wisdom not to retreat too soon or insist to absurd lengths [6]. It is, like prudence and justice, a virtue necessary for the acquisition of other virtues. In healthcare, it is tenacity that allows the health professional to use the power conferred to them to help patients in the appropriate way, even acting against a pre-established system, which imposes, above all, cost reduction, difficulties in accessing more expensive treatments and a choice of the best patients [6]. In short, fortitude is the medical virtue that inspires confidence in health professionals to resist the temptation to diminish the patient's good, whether because of their own fears, or due to social and bureaucratic pressures, and towards using their own capabilities and training efficiently to achieve the social good.

Temperance

Temperance is the virtue that controls appetites, which represents victory over selfish desires and temptations [6]. In healthcare, the health professional holds expert knowledge that matters to the patient, what grants them great authority and power and thus can cause them to fall into paternalism. The professional acts with temperance when using this knowledge for the good of the patient above any other individual or institutional interests, such as by refusing the misuse of medical technology in situations in which there is no proof of benefit to the patient or by avoiding the excessive use of unnecessary interventions. It is a virtue that requires—perhaps more than any other—an excellent awareness of the healthcare professional regarding the patient's conditions, values, and aspirations; a more intimate relationship, called therapeutic parsimony by Pellegrino and Thomasma [6].

Integrity

Integrity defines the nature of the individual who possesses all the other virtues. To characterize someone as upright is to attest the predictability that their reactions will be appropriate to specific situations and that their judgments will encompass the most important elements for decision-making, such as principles, virtues, precepts and other virtues [6]. In a context of illness, it is the health professional who interprets the circumstances and decides how to act based on ethical and bioethical principles and the relationship between them and the patient's values and aspirations. The professional must have integrity in the choices they make and in the in the way they present the facts to the patient, as well as in the respect they show the patient [6]. When in conflict with institutional or social issues, the health professional's integrity will motivate them to remain faithful to their commitments and to their own values, even when facing difficulties and temptations to abandon them [22]. On the other hand, it can be required by the patient or their family to perform unconventional treatments, which have the potential to harm patients or who violate the moral integrity of the health professional [23]. In these cases, the upstanding professional must refuse and propose viable alternatives. It is, therefore, a virtue that benefits primarily its possessor, who will safeguard good professional and character development to then act for the benefit of others.

Criticisms of Pellegrino and Thomasma's view

There are, however, a number of criticisms of the virtue approach to medical practice.

Veatch [24], after the first publication of Pellegrino and Thomasma [4], presented objections according to which there are a large number of virtues proposed and analyzed throughout history, which implies that they are linked to each culture, causing the theory of virtue to not be able to stand alone in a modern, pluralistic and secular society. Moreover, contemporary medicine would be a medicine of strangers [24], which would thus require a greater concern with correct conduct—it could not be safeguarded by ethical or moral models, especially in urgent and emergency situations in healthcare.

Pellegrino and Thomasma[6] respond to these objections by arguing that, similarly to the virtues, principles are interpreted according to culture, as well as most people's moral sense. Thus, the authors' proposal prescribes the joint interpretation of virtues and bioethical principles, which would function as elements of complementarity in order to guide each other. Furthermore, the laws or internal rules of institutions do not guarantee that evil will be avoided and good achieved, but it is preferable that we have professionals who have qualities that drive them to do good instead of being concerned primarily with their own interests [6].

Most recently, Oakley [25] argued that Pellegrino and Thomasma's perspective does not function as an autonomous approach in the field of virtue ethics to medical practice, but only as a supplementation to deontological and consequentialist views of bioethics. Obviously, the authors' view is out of date in relation to the current scenario, two decades after its main publication. However, it seems correct to state that the proposal serves minimally as a substrate to support a more contemporary virtues approach model to bioethics.

Final considerations

In this article, a brief exposition was developed regarding the reasons why virtues can and should be used as a theoretical and practical framework for the practice of medicine and healthcare as a whole, and the main virtues of the health professional proposed by Pellegrino and Thomasma were presented. Fidelity to trust, compassion, prudence, justice, fortitude, temperance, and integrity, all represent an excellency of character that greatly contributes to the development of the health professional and to the achievement of the goals of medicine.

When involved in the practice of healthcare, professionals voluntarily assume specific obligations and commit themselves to the purposes of medicine. Similarly, they are committed to the principles that must guide their actions in order to obtain the necessary ends. Virtues, for example, empower the agent to practice moral choices in a way that, in most cases, lead to the appropriate ends of medicine. This indicates that principles and virtues, working together, allow the agent to act as both an end and a means through the proper motives for acting.

It should be noted, however, that, just as bioethical principles are no longer limited to those proposed by the Belmont report and by Beauchamp and Childress, the virtues applicable to bioethics, whether general or clinical, are also not restricted to those highlighted by Pellegrino and Thomasma. Bioethics, virtue ethics and healthcare have evolved a lot in the last two decades, which implies that new perspectives and new principles and virtues can still greatly contribute to the improvement of theoretical and practical knowledge of healthcare.

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