Philosophy and Medicine

& 114

James A. Marcum

The Virtuous Physician

The Role of Virtue in Medicine

Springer

THE VIRTUOUS PHYSICIAN

Philosophy and Medicine

VOLUME 114

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THE VIRTUOUS PHYSICIAN

The Role of Virtue in Medicine

by
JAMES A. MARCUM
Baylor University, Waco, TX, USA

Springer

Dr. James A. Marcum
Baylor University
Dept. Philosophy
One Bear Place #97273
Waco Texas 76798
USA
James_Marcum@baylor.edu

ISSN 0376-7418
ISBN 978-94-007-2705-2 e-ISBN 978-94-007-2706-9
DOI 10.1007/978-94-007-2706-9
Springer Dordrecht Heidelberg London New York

Library of Congress Control Number: 2011943759

No one in this world always does right.
Ecclesiastes 7:20 (CEV)

Preface

Fundamentally, medicine is moral (Pellegrino, 2002; Tauber, 1999). It is neither a natural nor a social science, although it often depends upon both for its technical and communal progress. Medicine, especially as a clinical practice, is moral because the defining element of its practice is the patient-physician relationship; and, that relationship is profoundly principled and often based upon ethical rules and duties.[1] The relationship is moral also since the physician's behavior and not just his or her medical knowledge is critical for the patient's wellbeing and possible healing. Finally, it is moral since the ethical mandate of medicine, with respect to the physician's action, is to help—and not to harm—the patient. To harm the patient, either intentionally or unintentionally, is to fail at medicine's primary ethical mandate that dates back to Hippocrates. For both the patient and society call upon the physician to benefit the sick and dying and to assist in the healing process. From this perspective, both the natural and social sciences support the practice of medicine but do not define it. Thus, the physician's behavior, whether good or bad, is not peripheral to the clinical encounter but at the heart of what it means to be a healthcare provider.

Beginning in the late nineteenth century and culminating in the aftermath of Abraham Flexner's 1910 Carnegie Report, the scientific dimension of medicine eclipsed its moral or ethical dimension. This eclipse is the root cause of several crises now facing modern medicine. The first is the quality-of-care crisis. With the advent of a highly technical medicine, often the physician forgets that the patient is a person first. "Our nation's health care system," according to Ralph Snyderman, "has lost its way over the last two decades. It has become so enamored with technology and specialization that it has lost sight of individuals and their needs" (Blumer and Meyer, 2006, p. 5). Patients no longer feel that physicians are concerned about them as persons but only as pathological specimens. A crisis closely associated with the quality-of-care crisis is professionalism in medicine. Many physicians

[1] Although moral and ethical are often used interchangeably, an important distinction exists between them. Moral refers to an individual's assessment of personal character or behavior as good or bad, while ethical refers to a social assessment of an action as right or wrong—particularly with respect to codes or rules. I try to keep this distinction in mind; but, I do use ethical quite often as an all-inclusive term.

and even some patients view the medical profession as a collection of technical specialists, and the only skill needed to practice medicine is simply scientific or mechanical knowledge. This technical dimension of medicine can obviously exacerbate the quality-of-care crisis. Many patients often perceive their physicians as cold and uncaring technicians or mechanics, who are only interested in them as diseased body parts and not as individual persons. In an effort to resolve these crises, some physicians attempt to reinstate the humanistic dimension of medical practice (Marcum, 2008). For example, Eric Cassell (2004) champions a notion of patient *qua* person to stem abuses associated with the biomedical model of clinical practice.

To address the quality-of-care and professionalism crises plaguing modern western medicine, I introduce a philosophical notion of virtuous physician. To that end, I discuss in the first chapter the nature of the two crises and contemporary efforts to resolve them, especially with respect to evidence-based and patient-centered medicine. I then briefly introduce the notion of virtuous physician and outline its basic virtues (and corresponding vices of the unvirtuous physician) in traditional terms of metaphysics, ethics, and epistemology. In the next chapter, I introduce and discuss virtue theory, along with virtue ethics and epistemology. I first examine virtue theory, particularly in terms of defining what a virtue is, followed by an analysis of virtue ethics, including its history. Specifically, I discuss and expound upon the notions of ethical or moral action in terms of virtues. At the end of the chapter, I discuss virtue epistemology, with respect to reliabilist and responsibilist intellectual virtues. In a following chapter, I discuss specific virtues, especially as they relate generally to medicine. I first examine the four cardinal virtues of prudence, courage, temperance, and justice. I divide these virtues into two categories, consisting of the epistemic or intellectual virtues (prudence) and the ethical or moral virtues (courage, temperance, and justice). I then examine the theological or transcendental virtues of faith, hope, and love. In addition, I discuss cognate virtues to each of the cardinal and theological virtues.

In the fourth chapter, I explore the ontological priority of caring as the chief metaphysical virtue for grounding a notion of virtuous physician and of uncaring as the main vice of the unvirtuous physician. I then examine two essential ontic virtues of a virtuous physician—care and competence—and the two corresponding vices of an unvirtuous physician—carelessness and incompetence. In order for physicians to be competent in the practice of medicine, they must be genuinely caring (as an ontological attitude or stance). Because by caring physicians care about ($care_1$) patients as persons and strive to be technically or scientifically and ethically or morally competent, which in turn allows physicians to take care of ($care_2$) the individual patient's bodily and existential needs. Although caring (if limited to $care_1$) is inadequate to choose the correct or best course of clinical action, combined with the virtue of technical and ethical competence and with the virtue of $care_2$ it is adequate but still insufficient for practicing right or good clinical medicine. To be sufficient, competence must be transformed into prudence and care into love to form the compound or composite virtue of prudent love. In a following chapter, I

examine the transformation of competence into prudent wisdom and care into personal radical love to forge the compound virtue of prudent love, which is sufficient for defining the virtuous physician and the practice of virtuous holistic medicine. In contrast, imprudent lovelessness is the compound vice animating the unvirtuous physician and the practice of unvirtuous fragmented medicine.

In a penultimate chapter, I reconstruct two clinical case stories, both from the medical literature, which illustrate the various virtues and vices associated with medical practice. I utilize these case stories to illustrate the notion of virtuous and unvirtuous physician from an ethical and epistemological perspective. In the final chapter, I discuss how the notion of virtuous physician addresses the quality-of-care and professionalism crises and how the notion of unvirtuous physician exacerbates them. To that end, I utilize the notion of virtuous physician to integrate evidence-based and patient-centered medicine into a virtuous holistic medicine, which I then use in a separate section of the chapter to resolve the two crises. In contrast, the unvirtuous physician practices an unvirtuous fragmented medicine in which evidence-based and patient-centered medicine remain completely divergent. Lastly, I discuss the role of virtues in revising medical education at the undergraduate, graduate, and postgraduate levels and the question of whether the medical faculty can teach and students can learn virtues. My contention is that if the faculty does not teach and students do not learn virtues then the chance for vices to infect medical practice by default remains a viable option. In sum, the prudently loving physician is a genuine medical professional, who practices a holistic medicine that provides the quality of healthcare patients both expect and need.

Finally, I must address my motivation for writing this book and offer a defense for it, especially in terms of a non-clinician advising clinicians how to practice their trade—at least from a philosophical perspective. I have been associated with the healthcare field for almost my entire academic career. I have a doctorate in human physiology from the University of Cincinnati Medical College and conducted basic research on the regulation of hemostasis at Harvard Medical School for well over a decade. For the past decade at Baylor University, I have been participating in a medical humanities program at the undergraduate level. Through these experiences, I have come to appreciate first-hand the quality-of-care and professionalism crises facing modern medicine, especially from a philosophical or theoretical perspective; and, what is needed to address and resolve them. Moreover, I believe that not practicing medicine provides me with the ability to examine and analyze medicine and its practice objectively, without the encumbrance of biases and subjectivity that may attend those who must practice medicine on a daily basis. Lastly, my motivation for writing this book is to help those interested in pursuing or developing a medical career to understand that medicine is a difficult and demanding profession, especially in terms of its moral claim on its practitioners. In this book, I unpack in a philosophical analysis what this claim means in terms of virtuous physician and the practice of virtuous holistic medicine, and contrast it to the failure of the unvirtuous physician to provide quality healthcare in a professional manner.

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Acknowledgments

As true for most if not all authors, I have acquired a great many debts to others for their help. I am indebted especially to Kay Toombs and Bob Kruschwitz, as well as to Mike Attas, Bob Roberts, Bob Rose, Bill Stempsey, and Fred Tauber, for their invaluable discussions and insightful comments on earlier drafts of the book as a whole or in parts. Several chapters contain material reworked from articles appearing in *Theoretical Medicine and Bioethics* (Marcum 2009a), *International Journal of Science in Society* (Marcum, 2009b), *Medicine Health Care and Philosophy* (Marcum, 2011a), *International Journal of Health Wellness and Society* (Marcum, 2011b), and *Journal of Evaluation in Clinical Practice* (Marcum, 2011c). And, I thank Baylor University for supporting my scholarship with a sabbatical award and a URC grant. Next, I thank my daughters, Meg and Meredith, for their loving support, which has enriched both this book and my life. Finally, I dedicate the book to my students, who hope to practice medicine some day sensitive not only to the physical needs of patients but also to their emotional, psychological, and spiritual needs, and to the memory of my sister, Nancy, who first introduced me to the healing arts.

Contents

Chapter 1
Medicine's Crises

Modern western medicine, especially in the United States of America, is facing a number of crises, including economic, malpractice, healthcare policy, quality-of-care, professionalism, public or global health, primary or general care and critical care, and healthcare insurance—to name a few (Cutler, 2004; Daschle, 2008; Relman, 2007a). For example, the cost of medical care in the United States is the highest in the world. The total amount of money Americans spent on healthcare in 2007 was over 2.4 trillion dollars, and economists project the total healthcare costs to exceed well over 4 trillion U.S. dollars by 2018 (Sisko et al., 2009).[1] Related to the crisis of healthcare cost is the crisis of healthcare access. Until the recent passage in March 2010 of the US healthcare reform bill, over 45 million Americans were uninsured medically and often have little, if any, access to healthcare (Anonymous, 2009). Under dire circumstances, many uninsured use hospital emergency facilities; and they are generally unable to pay fully for the healthcare they receive, which exacerbates the cost crisis (Kotlikoff, 2007). Solutions to these crises are not readily apparent and pundits debate about how best to resolve them—although the current US healthcare bill, dubbed "Obamacare" by critics, promises to rectify the problems (Bristol, 2010). Two other important crises include quality-of-care and medical professionalism. Although efforts have been made to resolve them, with little success, I introduce the notion of virtuous physician to address them.

1.1 Medicine's Crises

In this section, I expound upon the quality-of-care and professionalism crises to provide a backdrop for motivating the need for a notion of virtuous physician. Although medical science and technology have produced, during the twentieth century, "miraculous" cures for many diseases such as infectious diseases, patients are often dissatisfied with the quality-of-care received from modern medical professionals. "I have a deep concern," acknowledges Arthur Kleinman, ". . .that at the same time that we are enabling doctors to become technologically effective we are

[1] On average, the amount of money spent individually on healthcare in 2006 was over $7400.

J.A. Marcum, *The Virtuous Physician*, Philosophy and Medicine 114,
DOI 10.1007/978-94-007-2706-9_1, © Springer Science+Business Media B.V. 2012

disabling them from being humanly compassionate and responsive" (Blumer and Meyer, 2006, p. 8).[2] A related crisis is professionalism, in which a variety of factors deprofessionalizes medical personnel. According to Edmund Pellegrino, "the [medical] profession is losing its commitment to the kind of character traits requisite for protection of the welfare and interests of patients" (2002a, p. 384).

The above crises are products of two clashing cultures—the scientific and the humanistic. Patients seek from professional caregivers not only scientific or technical cures for or management of their physical or organic ailments but also humane care for the psychological, emotional, and existential dimensions of those ailments. Modern medicine, however, often emphasizes technical cure and management of disease over humane care, and a technical professional character over a humane one. This emphasis on the scientific or technical begins with the education and training of physicians, who are obliged to meet scientific requirements as undergraduates for entrance into medical school—generally with no requirements in the humanities. And, once in medical school, the scientific and technical training in medicine of prospective physicians often brackets from the clinical consultation the patient's illness experience and any emotions associated with it. This training generally results in a medical professional who is emotionally detached from what the patient feels or experiences and who thereby appears uncaring to the patient.

1.1.1 Quality-of-Care Crisis

Although physicians always presume the highest quality of healthcare in their practice, quality became a critical issue in the early 1970s with the proposal of the federal HMO Act (Caper, 1988; Gruber et al., 1988). The U.S. Senate Health Subcommittee convened hearings to assess the impact of HMOs on healthcare quality. The concern was how best to measure the quality-of-care patients receive in order to determine whether HMOs would compromise that quality. To assess quality care quantitatively required a precise definition of it. Unfortunately, members of the committee discovered that no such definition, exhibiting community consensus, was available.[3] In response, concerned pundits and professional communities offered a plethora of definitions for quality-of-care throughout the decade. For example, the pediatric community assembled a committee to formulate an operational definition for quality pediatric healthcare. That community defined such quality accordingly: "Quality pediatric medical care embodies a scientific approach to health supervision; the

[2] David Weatherall also acknowledges a care crisis: "the art of medicine, in particular the ability of doctors to *care* for their patients as individuals, has been lost in a morass of expensive high-technology investigation and treatment. . .In short, modern scientific medicine is a failure" (1996, p. 17, emphasis added).

[3] Philip Caper (1974) also acknowledged the "elusive" nature of quality-of-care and proposed objective standards for medical procedures to define it, especially standards established through clinical trials.

establishment of a diagnosis of deviation from optimum health; institution of appropriate therapy; and management designed to satisfy the overall needs of the patient" (Osborne and Thompson, 1975, p. 625).[4] Towards the end of that decade, Avedis Donabedian—who Grant Steffen (1988) called the "Dean of Quality Assessment"—defined quality-of-care as "the application of medical science and technology in a manner that maximizes its benefits to health and minimizes its risks" (1979, p. 278).[5]

In the following decade, the healthcare quality issue took on new life (Caper, 1988). What added to that life were spiraling healthcare costs and efforts to contain them. The fear, not only in the governmental sector but also in the private and public sectors, was that cost containment would inevitably lead to reduced quality care. The need for a precise definition of quality-of-care became urgent so that interested parties could measure such quality accurately and ensure the highest possible quality of medical care at a reasonable cost (Lohr et al., 1988). Again, pundits and professional societies rose to the occasion and proposed a variety of definitions for quality-of-care. For example, the American Medical Association (AMA) formulated a definition of quality healthcare at its 1984 annual meeting. The AMA defined quality care as that care "which consistently contributes to improvement or maintenance of the quality and/or duration of life" (Council on Medical Service, 1986, p. 1032). The AMA also included eight characteristics in their definition of quality healthcare, ranging from adequately documenting the patient's record to optimally improving the patient's condition. Interestingly, the focus on quality-of-care represented the AMA's effort to renew its commitment to excellence in healthcare, particularly through initiatives in medical education, ethical reflection, preventive medicine, quality assurance, among others (Anonymous, 1986).

In an effort to bring some semblance of accord to the debate over quality-of-care, Steffen (1988) criticized select definitions that he claimed are representative of the myriad definitions proposed for quality healthcare. Specifically, he claimed that the AMA's definition is circular in nature in that the AMA used quality as both the definiendum and definiens. In addition, he complained that the AMA's definition fails to connect the eight characteristics of quality healthcare in order to define quality-of-care adequately. Although he largely agreed with Donabedian's definition, he quibbled with whether quality is a property medical care exhibits

[4] David Rutstein and colleagues proposed another widely recognized definition of quality medical care by defining quality as "the effect of care on the health of the individual and of the population," where care pertains to "the application of all relevant medical knowledge" (Rutstein et al., 1976, p. 582).

[5] Donabedian (1990) identified seven characteristics, or what he called pillars, that define the nature of quality-of-care. The first is efficacy, which represents the ability to affect a cure or to improve a patient's wellbeing, while the second is effectiveness and involves the realization of a cure or an improvement of a patient's wellbeing. The next is efficiency, which represents maximal treatment at minimal cost, while the next related characteristic is optimality and pertains to optimal balancing of risks and benefits. Two subsequent characteristics are acceptability, representing patient's approval of medical goals, and legitimacy, involving society's sanction of those goals. The final characteristic is equity or fair distribution of medical care.

in varying degrees to balance risks and benefits. According to Steffen, quality is not a metaphysical property of care but rather a preference or value for choosing a particular type of care. Finally, he criticized David Rutstein's definition for equating quality with the outcome of medical care. For Steffen, quality represents the capacity to achieve such an outcome. He goes on then to define quality medical care as "the capacity to achieve the goals of both the physician and the patient" (Steffen, 1988, p. 59). The goals represent legitimate medical outcomes negotiated by both the patient and physician. Steffen concluded with the hope that the proposed definition provides "a point of departure rather than a final statement in this dialogue on the nature, assessment, and improvement of quality medical care" (1988, p. 61).[6]

During the 1980s, the spiraling costs of the Medicare program prompted the U.S. Congress to examine quality medical care and its assessment. The Congress charged the Institute of Medicine (IOM), a division of the U.S. National Academy of Sciences, with the task. In 1990, the IOM released a two-volume report, *Medicare: a strategy for quality assurance*, detailing its findings and recommendations.[7] Kathleen Lohr was the editor of the report. Lohr and colleagues at the IOM were responsible for the most recognized and often cited definition of quality healthcare (Blumenthal, 1996a; Bowers and Kiefe, 2002; Zipes, 2001). "Quality of care," according to the IOM, "is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Lohr, 1990, p. 4). The definition represents the consensus of around one hundred definitions in the literature. In addition, the report cites eight characteristics of quality medical care, selected from eighteen. The characteristics range from the scale of quality to technological restraints on care. Although the definition struck a chord with many, it failed in one important aspect—it over emphasized the technical or practical nature of medical care.

In the lead article to a series of six articles on the quality issue in medicine, which appeared in the *New England Journal of Medicine*, David Blumenthal (1996a) reviews the history of efforts to define quality-of-care in medicine.[8] Blumenthal notes that many of the definitions for quality medical care emphasize the technical or practical dimension of such care. This dimension includes two important aspects. The first is the appropriateness of the medical care, whether the care is what the patient needs to improve or restore health. The second aspect of technical care is the physician's performance of that appropriate care. In other words, quality technical care represents the best clinical practice done correctly. However, Blumenthal identifies another aspect of care, especially with respect to the patient-physician

[6] In utter frustration with the healthcare community's efforts to define quality-of-care precisely or even adequately, Caper (1988) declared a ban on the word quality from discussions on assessing healthcare. In its place, he proposed a pragmatic approach in which interested parties simply measured the "components" of care, such as efficacy and appropriateness.

[7] For a summary statement of the IOM report, see Lohr and Harris-Wehling (1991).

[8] For a conceptual analysis of quality healthcare definitions, see Harteloh (2003).

relationship. That aspect involves "the quality of their communication, the physician's ability to maintain the patient's trust, and the physician's ability to treat the patient with 'concern, empathy, honesty, tact and sensitivity'" (Blumenthal, 1996a, p. 892). Although he does not name or develop this aspect of quality medical care, others do.

Besides the technical or practical dimension of quality medical care, Donabedian (1979, 1988) acknowledges what he calls its interpersonal dimension. This dimension involves "conformity to legitimate patient expectations and to social and professional norms" (Donabedian, 1979, p. 277). Donabedian identifies the interpersonal dimension with the art of medicine, in contrast to the technical or scientific dimension of quality medical care. Caper (1974, 1988) also acknowledges an interpersonal dimension of quality healthcare.[9] He identifies this dimension with the "process of caring for the patient—the interpersonal, supportive and psychological aspects of the physician-patient relationship" (Caper, 1974, p. 1137). Both Donabedian and Caper claim that medical professionals too often ignore the interpersonal dimension of healthcare but that patients do not. Part of the reason why physicians are likely to ignore this dimension of quality healthcare is that the interpersonal dimension is too subjective, making it almost impossible to measure accurately by standard criteria used to measure the technical dimension of quality medical care.

Although problems certainly exist with defining quality-of-care in terms of assessing and improving it, these problems did not precipitate a crisis for technical quality care but rather only a debate; however, problems with defining technical quality healthcare, in order to measure and improve it, did contribute to the malpractice crisis. Thus, the contemporary crisis in quality-of-care is not a result of its technical dimension per se but of its existential dimension. "Measuring the quality of medical care predominantly by heart beats and body heat," Eric Cassell notes, "is one of the reasons modern medicine got into its current difficulties—focused more on diseased organs and technology than on the goals of sick persons. Patients do not simply want to survive," he goes on to stress, "they want to survive in order to live a life in which they can recognize themselves and in which their values are preserved" (1997, p. 130). The real crisis of quality care pertains then to patients' perceived indifference by physicians to their existential needs. As Brian Berman so succinctly articulates these needs, "Yes, you want your physician to be highly skilled, to be extremely knowledgeable, in medicine. But in addition to that, you want them to know you as a person" (Blumer and Meyer, 2006, p. 6).

In response to the interpersonal dimension of quality healthcare, Steffen proposes the addition of a ninth characteristic of care to the AMA's eight: "care of high quality includes assessment of patient goals and values" (1988, p. 57). Although the

[9] See also Campbell et al. (2000) for further discussion of the interpersonal dimension of quality medical care.

physician and patient share the goal of improving a patient's health or returning a patient to full health, this goal, which is often technical in nature, may not be the only important goal for the patient. Other goals, especially existential ones, may also be significant to the patient vis-à-vis holistic healing. According to Steffen, these goals "refer to the nontechnical or interpersonal aspect of care, the art of medicine; these goals usually are not achieved by tests or therapies but by attention to those patient values that generated them" (1988, p. 59). Although physicians cannot measure these goals accurately, their awareness of them can improve the overall quality of healthcare and lead not only to patient wellness but also to physician satisfaction.

During his career, Donabedian strove to combine the technical and the interpersonal dimensions of quality healthcare to attain a single, unified definition.[10] According to Donabedian, such a unified definition of quality medical care "is expected to maximize an inclusive measure of patient welfare, taking account of the balance of expected gains and losses that attend the process of care in all its parts. This is a process fundamental," emphasizes Donabedian, "to the values, ethics, and traditions of the healthcare professions: at the very least to do no harm; usually to do some good; and ideally, to realize the greatest good [i.e. quality healthcare] that is possible to achieve in any given situation" (1979, p. 278). Of course, he is well aware that realization of such quality-of-care belies the complexity of healthcare itself. Although Donabedian is apprehensive about the possibly of realizing such an ideal quality care, he recognizes that such care is context dependent and subject to the norms and values of the medical profession, patients, and the society in which both reside.

In summary, medical care exhibits two dimensions that are relevant to the current quality-of-care crisis. The first is the technical dimension of quality medical care. Although physicians and patients are concerned about this dimension, physicians are confident that quality healthcare is adequately definable to ensure precise measurement in order to improve healthcare quality—even though they acknowledge that the nature of quality is often a moving target (Blumenthal, 1996b; Zipes, 2001). The second dimension is interpersonal and existential in nature. This dimension represents the patient's emotional or psychological needs and is responsible for the quality-of-care crisis that permeates the healthcare industry—at least from the patient's perspective. For, the interpersonal dimension of quality of medical care concerns patients most. In commentary on the future of quality healthcare, David Blumenthal and Arnold Epstein (1996) claim that the physician, especially in terms of the patient-physician relationship, represents a key component in the resolution of this crisis. My contention is that the notion of a virtuous physician helps to address and resolve it.

[10] Caper also envisions a unified notion of quality healthcare: "In medical care, its objective [technical] and subjective [interpersonal] characteristics are woven into a single fabric" (1974, p. 1137).

1.1.2 Professionalism Crisis

A related crisis to the quality-of-care crisis in modern medicine is professionalism (Relman, 2007b; Smith, 2005; Swick et al., 2006).[11] A physician's unprofessional behavior may result in the delivery of poor or less than adequate healthcare. The question that fuels this crisis is what type of physician best addresses the patient's total healthcare needs and fulfills medicine's social contract. The answer to this question involves the physician's professional demeanor or character. Importantly, that demeanor is a function of the social contract between the medical profession and the larger public. In the early 2000s, several medical societies launched the Medical Professionalism Project to update the social contract for twenty-first century medicine (Project of the ABIM Foundation et al., 2002). The professionalism crisis is currently reaching fever pitch, and commentators are spilling much ink over the crisis. For example, special issues of *Academic Medicine* and *Perspectives in Biology and Medicine* recently published articles devoted to the nature of professionalism and especially to whether professionalism can be taught (Humphrey, 2008; Whitcomb, 2007a).[12] In this section, I examine briefly the history of professionalism in medicine, especially in the United States. I then discuss the nature of the current medical professionalism crisis, especially the efforts to define medical professionalism. I also discuss the Medical Professionalism Project's charter and its impact on the practice of medicine.

According to Matthew Wynia (2008), the date of medicine's nascence as a profession is the same as medical professionalism's nascence. Although many look traditionally to the Hippocratic period—especially in terms of the Hippocratic Oath—for the birth of medical professionalism, several problems confront this interpretation of medical professionalism's origin. For example, Hippocratic physicians did not represent the majority of Greek physicians in terms of medical standards of practice, especially in terms of end-of-life issues (Miles, 2004). According to Wynia, neither the Medieval Age nor the Renaissance represents the origin of medical professionalism because no universal standards for medical behavior were operative then. In fact, he even rejects Thomas Percival's *Medical Ethics* as the source of medical professionalism for the same reason. Not until the AMA's 1847 Code of Medical Ethics is medicine's nascence achieved, claims Wynia, although maturity is several decades off. What initially defined this code is a tripartite contract between physicians and patients, physicians and colleagues, and physicians and their professional societies. However, what eventually became problematic for the medical practitioners is how best to define their professionalism. Is professionalism simply reducible to an ethical code or does it require more?

[11] Professionalism, along with evidence based medicine and patient safety, is part of a quality-of-care movement in modern medicine (Hafferty and Levinson, 2008).

[12] Holly Humphrey (2008) notes that over 1500 articles appeared in the literature during the six years intervening from the founding of the Medical Professionalism Project to her introductory essay for the *Perspectives in Biology and Medicine* special issue on professionalism.

Although defining medical professionalism is elusive, just as defining quality-of-care is, Herbert Swick (2000) provides a contemporary definition, which has been influential. According to Swick, "medical professionalism consists of those behaviors by which we—as physicians—demonstrate that we are worthy of the trust bestowed upon us by our patients and the public, because we are working for the patients' and public's good" (2000, p. 614). Since he strives for a normative definition of medical professionalism, Swick identifies nine behaviors essential to the definition. The first is the subordination of the physician's interests to those of others, especially patients, for their betterment. The next behavior requires physicians to endorse and adhere to high ethical standards. The third behavior pertains to the social contract between medicine and society. That contract, in terms of its duties and obligations, must guide a physician's behavior in meeting the medical needs of patients. The next behavior involves humanistic values, such caring, compassion, honesty, integrity, among other, which should animate a physician's solicitude for a patient. Physicians should also be accountable to peers and patients for their professional behavior. They should also be committed to both excellence and scholarship with respect to their technical competence. Finally, given the complexity and uncertainty of medical practice, physicians should develop reflective and deductive practices and skills to dispense healthcare in a just and objective manner. As Swick admits, the purpose of his effort to provide a normative definition is to stimulate dialogue in the medical community to strive towards a consensus definition. That effort bore fruit in a number of definitions for medical professionalism, at the level of medical communities (Hafferty and Levinson, 2008).

In 1999, the American Board of Internal Medicine, the American College of Physicians and American Society of Internal Medicine, and the European Federation of Internal Medicine formed the Medical Professionalism Project.[13] Members of the project's committee included Troy Brennan as chair, along with members from each of the societies and several special consultants. The goal of the Project was "to develop a 'charter' to encompass a set of principles to which all medical professionals can and should aspire" (Project of the ABIM Foundation et al., 2002, p. 244). The charter, called a Physician (or Physicians') Charter, was published simultaneously in 2002 February issues of the *Annals of Internal Medicine* and the *Lancet*.[14] In the charter, committee members identify three principles, with nine associated professional responsibilities. The first principle is the primacy of the patient's welfare, in which the physician exhibits an altruistic stance towards patients and their healthcare needs. The next principle is patient autonomy, in which physicians empower patients to make the best decisions as to their healthcare. The

[13] Frederic Hafferty and Dana Levinson (2008) identify such efforts to address professionalism in the practice of medicine by professional communities as the fourth wave of medicine's professionalism movement. The first three waves include the emergence of professionalism as an issue vis-à-vis challenges such as the commercialization of medicine, attempts to define professionalism, and efforts to measure it.

[14] The charter also appeared in the May issue of the *European Journal of Internal Medicine*.

final principle is social justice, in which physicians endeavor to distribute healthcare resources fairly. The nine associated responsibilities include commitments to enhancing professional competence and scientific knowledge, developing honest and appropriate relations with patients and maintaining patient confidentiality, improving quality and access to healthcare, distributing healthcare resources justly, and managing conflicts of interest to maintain patient trust. The charter ends with recognition of medicine's social contract and the maintenance of the contract though rededication to the above principles and responsibilities of professionalism.

In a 2003 May issue, the *Annals of Internal Medicine* carried a 15 month report of the charter's impact upon the medical profession (Blank et al., 2003; Eldar, 2003). Around a dozen professional medical journals published the charter, including *American Journal of Obstetrics and Gynecology*, *American Journal of Surgery*, *Canadian Medical Association Journal*, *Clinical Medicine* (journal for the Royal College of Physicians in the U.K.), *European Journal of Internal Medicine*, *La Reveu de Médecine Interne*, and *Medical Journal of Australia*. The charter was translated into almost a dozen languages, including German, Italian, Japanese, and Turkish. Members of the charter's committee gave more than one hundred professional presentations at national and international medical conferences, grand rounds, seminars, and workshops. Moreover, almost one hundred professional associations and societies, medical schools, and certifying boards adopted or endorsed the charter. Finally, the charter received considerable public attention through newspaper, radio, television, and internet coverage.

Although the charter's overall impact upon the medical community was positive, critics did raise objections and challenges to the charter. For example, the 2003 May issue of *Annals of Internal Medicine* included an editorial by Stanley Reiser and Ronald Banner and over a half-dozen letters to the editor. In their editorial, Reiser and Banner (2003) praise the charter for addressing contemporary issues facing medical professionalism; however, they raise concern over the lack of input from patients and patient advocacy groups in the charter's formulation. The outcome is "rhetoric [that] portrays physicians at a distance from patients" (Reiser and Banner, 2003, p. 845). Their recommendation is to revise the charter to include the patient's voice and to include the patient as partner.[15] Letters to the editor raise a number of objections and concerns with the charter. For example, the first letter, as do others, points out that the Hippocratic Oath is sufficient for defining medical professionalism—no additions or revisions are necessary. Another letter chastises the charter's framers for advocating conflicting principles. Specifically, the principles of patient welfare and of social justice conflict since the former principle presupposes individual rights while the latter group rights and both are exclusive. Other letters are more conciliatory, attempting to extend the charter's role in the discussion on medical professionalism. For example, one correspondent claims

[15] In commentary on the charter, Laine Ross (2006) points out that the charter's framers marginalized the patient by shifting from a principle of respect for persons to respect for patient autonomy.

medicine is a lifestyle and that the charter should include the mentoring role of physicians. In response to these criticisms, the charter's framers express delight that the charter opened lines of communication over the professionalism crisis.

The charter continues to influence the medical community's efforts to address the professionalism crisis (Hafferty and Levinson, 2008). Its most significant impact, however, is paving the way for an organizational approach to the medical professionalism crisis.[16] For example, in one of the letters to the editor in the 2003 May issue of *Annals of Internal Medicine*, the correspondent—a healthcare administrator—encourages the charter's framers to revise the charter to include the organizational or administrative level of healthcare. Rather than focusing just on the behavior or responsibilities of individual physicians, medical professionalism must also include its social responsibilities—especially in terms of medicine's social contract (Cohen, 2007). Hafferty and Levinson (2008) provide an important instance of the organizational dimension of medical professionalism with respect to the social contract—conflict of interest (COI). Although COI issues are not new to medicine, they highlight the problems associated with modern medicine as it attempts to negotiate the demands to provide quality healthcare for patients in a profession that includes business and industry interests. Recently, the chair of the Physician Charter, along with several colleagues, issued a policy proposal for medical schools and academic centers to limit the influence of the healthcare industry vis-à-vis COI (Brennan et al., 2006).

Although the organizational dimension does include the social realm, its focus is still on the individual physician and his or her ability to maintain professional integrity in the face of compromise, e.g. COI situations. According to Hafferty and Levinson (2008), the problem is that efforts to frame medical professionalism so far fail to capture the complexity of modern medical practice. To address this complexity, they propose a systems approach to medical practice and professionalism.[17] Hafferty and Levinson "suggest reframing the issue of professionalism. . .from a matter of individual motives, or even as an object of remedial actions at the organizational level, to that of a complex, adaptive system where social actors, organizational settings, and environmental factors interact" (2008, p. 608). To illustrate their proposal, they discuss medical school as a complex system vis-à-vis medical professionalism. Specifically, they locate professionalism within the complexity of formal, informal, and hidden medical school curricula. For the formal curriculum, professors can teach professionalism in the classroom setting. However, to leave the conveyance of professionalism at that level would open the possibility for distorting what it means to practice medicine professionally. Medical students also need to learn professionalism at an informal level in which medical professors mentor students. Finally, professors must model what medical professionalism looks

[16] Hafferty and Levinson (2008) identify such efforts as the fifth wave of medicine's professionalism movement.

[17] Hafferty and Levinson (2008) denote this systems approach as the sixth wave of medicine's professionalism movement.

like on the hospital or clinical wards, at level of the hidden curriculum.[18] Only by approaching medical professionalism from a systems perspective, conclude Hafferty and Levinson, in which actors (professors and students) engage each other at various organizational settings (classroom, hospital, or clinic), given specific environmental factors (COI or other ethical dilemmas), can students adequately learn to practice medicine professionally.

Finally, in an analysis of the charter, Swick and colleagues, review its foundations and offer an alternative foundation (Swick et al., 2006). According to these commentators, the conceptual foundation of the charter is a duty-based ethic. The charter's language is contractual in nature, reflecting a relationship of distrust between the patient and physician. Swick and colleagues endeavor to switch the charter's duty-based ethic to one of virtue, since "medicine is to a large extent a moral enterprise precisely because the physician must merit the patient's trust" (Swick et al., 2006, p. 267). To that end, they enlist William Osler (1849–1919). Although Osler appreciates the new science and its advantages for medical practice, he also argues that the physician's character and the virtues animating that character are crucial for keeping the profession of medicine from becoming simply a trade. For Swick and colleagues, a duty-based ethic is inadequate for a higher form of medical professionalism. That higher form of professionalism, as opposed to a basic form, is covenantal in nature and places the patient's interests first. "The Physician Charter is one important step toward finding a common ground for understanding medical professionalism," conclude Swick and colleagues, "but the profession must move beyond the Charter's somewhat narrow focus on duty and competence to embrace the ideals, the genuine sense of selfless service, and the deep commitment to patients that have for so long epitomized the highest values of medicine" (Swick et al., 2006, p. 273).

In summary, just as pundits divide quality-of-care into two types so they divide professionalism (Swick et al., 2006). The first type of professionalism is practical or technical in nature. Just like technical quality-of-care, practical professionalism pertains to the competent application of current standards or guidelines of medical care in terms of diagnosis and therapy. For the most part, it became the defining feature of professionalism as medicine yoked itself to the natural sciences. Physicians are confident that improving their practical or technical professionalism is simply a matter of teaching medical students, interns, and residents to dispense such healthcare in a professional manner. No real crisis in professionalism exists with this type of professional, except for isolated issues. The second type of professionalism, which is moral in nature, does represent a crisis in medicine. This moral professionalism represents a selfless service to the sick and demands at times an altruistic attitude on the part of medical practitioners, which technical professionalism trumped several

[18] Importantly, Hafferty and Levinson (2008) argue that medical educators cannot successfully change the current hidden curriculum, with its negative impact on professionalism, without changes to both the formal and informal levels of the medical curriculum.

decades ago. Again, as for the quality-of-care crisis the notion of virtuous physician can help to address and resolve the professionalism crisis.

1.2 Resolving Medicine's Crises

In this section, I discuss the medical profession's attempts to resolve the quality-of-care and professionalism crises. To that end, I first explore evidence-based medicine (EBM) to improve healthcare quality and effectiveness. EBM is the consensus means for enhancing the technical dimension of quality medical care and hence of medical professionalism. To address the existential dimension of the quality-of-care crisis and the moral dimension of the professionalism crisis, I next examine patient-centered medicine (PCM). PCM represents the attempt of healthcare professionals to humanize the biomedical model, especially in terms of ethical virtues, thereby enhancing both the quality of medical care and medicine's professionalism. While the technical dimensions of both quality care and professionalism are measurable and thereby quantifiable, the existential or moral dimensions are not easily measurable. Improving the latter represents a challenge. Finally, how best to teach both existential or ethical quality-of-care and moral professionalism also represents a challenge.

1.2.1 Evidence-Based Medicine

Within the past several decades, medicine appears to be undergoing a revolution or paradigm shift—to turn a Kuhnian phrase—with respect to its practice. Rather than medical practice based upon an older paradigm of pathophysiology and clinical experience or expertise, advocates of a new paradigm, EBM, claim that medical practice should incorporate the best contemporary scientific data or evidence. Proponents of EBM rely less on traditional medical authority and more on systematic clinical and laboratory observations and data, especially obtained from randomized clinical trials and interpretation of that evidence though meta-analysis. This revolutionary claim is not without its critics; and the debate, although not as intense as it once was several years ago, still continues in some sectors of medicine over whether EBM is truly revolutionary.[19] For the most part, EBM enjoys a certain level of support and consensus within modern medicine. In this section, I examine what EBM is and how it addresses the quality-of-care and professionalism crises.

What is EBM? David Sackett and colleagues, who formed the Evidence-Based Medicine Working Group chaired by Gordon Guyatt, provide the best or most widely recognized and accepted definition of EBM: "the conscientious, explicit,

[19] Commentators also debate the proper philosophical framework for articulating EBM. For example, W.V. Quine and Larry Laudan's philosophy of science represent competing frameworks (Kulkarni, 2005; Sehon and Stanley, 2003).

and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al., 1996, p. 71). According to EBM advocates, best evidence represents results from randomized clinical trials and meta-analysis of those trials. For example, the Cochrane Collaboration provides periodic reviews of up-to-date evidence from clinical trials for how best to proceed in terms of clinical practice (Chalmers, 1993). Sackett and colleagues identify five steps for the practice of EBM: (1) articulating clinical question(s) concerning a patient's disease state, (2) discovering the relevant evidence within medical literature databases to answer the question(s), (3) appraising the evidence with respect to its validity or soundness and its clinical usefulness, (4) applying the evidence to the patient's clinical problem, especially in terms of the patient's values, and (5) formally evaluating the four steps to determine the effectiveness of the process (Sackett et al., 1998).[20]

Critics of EBM abound (Cohen and Hersh, 2004; Timmermans and Mauck, 2005). Leonard Gibbs and Eileen Gambrill (2002) divide the criticisms or objections leveled against EBM into six categories: objections from ignorance of EBM's nature, objections from misinterpretation of EBM standards, objections from appeal to traditional medical practice, objections from ad hominem arguments, objections from ethical concerns, and objections from philosophical problems.[21] For example, one of the popular criticisms of EBM, especially given the various steps required to practice it, is that it would result in "cookbook" medicine (Farquhar et al., 2002; Wood, 1999). The basis of this objection, according to Gibbs and Gambrill, is a misconception of EBM's nature. EBM proponents charge that the criticism fails to recognize that EBM's guidelines are not recipes that require strict adherence to ingredients but rather they are roadmaps for negotiating the bumpy terrain involved in patient care (Farquhar, 1997). Another important criticism is that EBM does not meet its own standards for evidence (Goodman, 2002). In other words, evidence from clinical trials is not available to demonstrate the effectiveness of EBM over traditional approaches to medical practice. EBM proponents argue that such criticisms help to define what EBM is not (Sackett et al., 1996; Pronovost et al., 2002).

Although critics of EBM abound, so do its defenders (Gibbs and Gambrill, 2002; Straus and McAlister, 2000).[22] However, the nature of EBM is evolving in light of these criticisms. For example, William Ghali and Peter Sargious (2002) note that a frequent criticism of EBM is that it is often impractical and unrealistic for busy physicians who may not have the time to evaluate critically clinical trials in order to

[20] Porzsolt and colleagues identify an additional step after the first step: attempting to answer the clinical question(s) based on a clinician's current level knowledge or experience (Porzsolt et al., 2003). This additional step helps the clinician to identify how best to incorporate EBM into a patient's care.

[21] For philosophical basis of and issues facing EBM, see Goldenberg (2006), Guyatt and Busse (2006), Howick (2011), and Sehon and Stanley (2003).

[22] Although EBM proponents claim they welcome criticism in order to advance EBM's application to the practice of medicine, opponents claim they are often ignored or marginalized from the discussion (Buetow et al., 2006; Miles and Loughlin, 2006).