OCCASIONAL PAPER 78

# Towards a Philosophy of General Practice: a Study of the Virtuous Practitioner

Peter D Toon, MSc, MRCGP

*Published by*
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**April 1999**

# The Royal College of General Practitioners



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Among its responsibilities under its Royal Charter the College is entitled to:

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# Preface

## Theory of general practice

The first glimmerings of a theory of general practice emerged in the first quarter of the twentieth century. Mackenzie (1916) commented on the doctor-patient relationship, but from a perspective of doctor dominance. Stark (1923) was among the first to describe the doctor-patient relationship as the key entity, but thereafter little happened until general practice had the strength to form its own academic organisation in 1952 - the then College of General Practitioners.

Then, within only five years, important steps were taken, 1957 being a watershed year. The new College adopted as its motto *Cum Scientia Caritas* (care with science), a brilliant encapsulation of the role of the general practitioner. Nowadays when mission statements have become the norm, few organisations have done better - even the General Medical Council's skilful "Protecting patients: Guiding doctors" takes four words to the College's three.

Thus two key elements of the theory of the role were written out (an inevitable first academic step in clarification). The science component was obvious, the interesting point is that as early as 1957 the doctor-patient relationship was seen as central.

There have been two main approaches to developing general practice theory: first the Balint-like relationship approach and secondly the generalism approach. The importance of the patient as a person has grown as all the other branches of medical practice have divided their fields into ever-smaller specialties. These now number over 50 and are continuing to increase. General practice alone remains committed to and is able to practise whole-person care.

The main themes of general practice theory have emerged as: a community, environmental setting, in which a generalist discipline ie whole person medicine, is practised within a patient-doctor relationship.

As far back as the time when the 1911 Insurance Act was introduced, general practitioners established themselves as a non-hospital community-based discipline, with immediate access and working in homes and with families. The patient's environment is always relevant in general practice. But general practice is more than a setting in which medical work is undertaken. It is the human aspects which make general practice special, whether it is the characteristics of the patient as a whole person, or the way that person relates to another whole person, the doctor.

## Generalists

The second theoretical approach to the analysis of the role emphasises breadth. Pereira Gray (1969) described the doctor-patient relationship as three-dimensional, using the term to indicate depth and solidity, but occurring through involvement with the patient in physical, psychological, and social problems simultaneously. The RCGP (1972) in its major theoretical text, *The Future General Practitioner* underlined this three-way approach. The College team saw general practice as medicine set in the context of human development, medicine and society, and practice organisation, all integrated together within the consultation.

The importance of generalists in medicine (Pereira Gray et al., 1994) led to the term "whole-person medicine" emerging as a key component of the discipline (Pereira Gray, 1995).

## Other disciplines

Different disciplines have analysed general practice and contributed to its understanding. Five academic fields stand out: psychiatry, sociology, psychology, epidemiology (including economics) and anthropology. Peter Toon now brings in a sixth - philosophy.

*(a) The psychiatric perspective - the doctor-patient relationship*

Balint's contribution was the first from a discipline outside practice to illuminate the role of the general practitioner. He came as a psychoanalyst and brought psychotherapeutic insights.

The importance of the doctor-patient relationship was powerfully enhanced by Balint's (1957) book, *The Doctor, His Patient, and the Illness*. This introduced more theory than any other text before it and is still widely quoted in the general practice literature 42 years later. Balint not only emphasised the uniqueness of the role; he also illuminated some of the components of it. He brought analysis to the understanding of traditional values. For example, with continuity of care, he used the analogy of a shared mutual investment. He used groups of generalists as both the medium and the measure.

Many years later Tudor Hart (1988) also used the concept of sharing in the doctor-patient relationship with the idea of "co-producers" and McWhinney (1996) stated that general practice is still relationship based.

*(b) The sociological perspective - the patient's point of view*

Ann Cartwright's (1967) seminal text, *Patients and their Doctors*, written from a sociological perspective, examined general practice through the patient's eyes. She focused on the then new topics of accessibility and patient satisfaction. Later, Tuckett et al (1985) carried this work further and saw the patient and doctor meeting as two experts.

*(c) The psychological perspective - theories of behaviour*

Another discipline which has contributed considerably is psychology, especially through such theories of behaviour as the health belief model (Kirscht, 1974).

*(d) The epidemiological perspective - the population approach*

The NHS registered list system gave general practitioners a defined denominator for their analyses. Epidemiology soon influenced the discipline through the National Morbidity Surveys (Logan and Cushion, 1958; RCGP, 1974). Cost effectiveness and cost efficiency are derivations of this approach.

*(e) The anthropological perspective - the importance of culture*

Helman (1981, 1984) raised the flag for culture and showed how great are the cultural implications of medicine, especially as practised in the community.

*(f) The perspective of philosophy - moral values and choices*

This Occasional Paper, taken with Peter Toon's (1994) *What is Good General Practice?* brings to general practice theory the discipline of philosophy. This approach adds several important elements to our understanding of the theory of general practice. It was first brought to the College through the John Hunt Lecture of 1994, delivered by the Reverend Professor Dunstan.

Toon's skill is to describe complex ideas and present them with clarity. He often illustrates a principle with an example from medicine, usually from general practice. He does not hide his own views as the use of words like "nonsense", or statements like "This is unreal" show.

He begins by discussing facts and values from a philosophical perspective. This includes discussion of what he sees as the uncritical acceptance of relativism. Later he analyses the contrast between the mechanical model and the humanistic model of care. He underlines the re-emergence of narrative and the patient's story within the humanistic approach. Interestingly, he is one of the first generalists to set confidence limits around the concept of autonomy and to argue for greater attention being given to the concept of benificence.

His chapter on the meaning of illness covers ground previously seen mainly from a sociological perspective such as the sick role (Parsons, 1951) or from anthropology (Helman, 1984). He emphasises the choice of externalization against internalization into the patient's narrative and the primary physician's role in helping the patient in that choice.

Marinker (1973) in his Gale Memorial Lecture, was the first to concentrate on the boundary role occupied by the general practitioner in society and he illustrated this by exploring the boundary between science and poetry as art. Heath (1995) has described the generalist patrolling several boundaries: between illness and disease, between self-care and doctor care, and between primary and secondary care.

Much of Toon's text is a case for doctors to take a more interpretive rather than mechanical view of their role. It is at least possible that some of the discontent that the public currently has with doctors may represent a cry from patients for this as well. In the closing sections, Toon tackles virtue, not a word, as he writes, that is much discussed nowadays. Here, in what is the climax of his work, he integrates moral philosophy going back to Plato and Aristotle, with religious teaching and clinical care. He is concerned about the impersonal, and what may become amoral, markets and calls for more attempts to measure the human side of medicine (Evans and Sweeney, 1998).

He describes the seven virtues and discusses each in relation to modern medicine especially in primary care, emphasising the essential humanness not just of the patient, but of the doctor as well. Throughout, he effectively translates key words into modern idioms. In his treatment of justice he tackles rationing.

## Meaning in medicine

No text on philosophy will ever be light to read, but this one is as easy as any. In the early 1980s, Helman (1981, 1984) wrote, as a general practitioner, about anthropology and illuminating cultural issues in general practice from within.

Now, a similar contribution comes from another working general practitioner bringing knowledge and understanding from philosophy and throwing light on general practice from yet another discipline.

To those who ask: "Is there no end? Is there always more to learn from ever more disciplines?" the answer can only be "Yes". The human body and the human mind are infinitely variable and infinitely challenging to understand. When set in the context of a person consulting a doctor, understanding the consultation is an immense intellectual challenge. It is given to clinical generalists to see the widest range of problems brought by the widest range of people. That is both the challenge and the privilege of being a general practitioner.

In the last 12 years or so the less personal approaches to medicine, such as markets, management, and evidence-based medicine (Sackett et al., 1985) have held sway. It may be no coincidence that the pendulum of thought is swinging again, back to the more human and personal aspects of care with greater emphasis on the patient's point of view. It may not be a coincidence that this is now the fourth *Occasional Paper* in the last five years to explore these ideas.

Baker (1990) on patient satisfaction, Heath (1995) resisting medicalization, McWhinney (1996) on patient- centred medicine, Howie et al. (1997) reporting "enablement" for patients and Sweeney et al. (1998) defining "personal significance" are five general practitioners all working with colleagues in the 1990s along these lines.

This Occasional Paper will give general practitioners food for thought. It adds interest to the work by advancing the theory of general practice and illuminating the meaning of medicine.

Sir Denis Pereira Gray
General Practitioner, Exeter
Honorary Editor, *Occasional Papers*
March 1999

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Alle Vergängliche
Ist nur ein Gleichnis;
Das Unzulängliche,
Hier wird's Ereignis;
Das Unbeschreibliche
Hier ist's getan;
Das Ewig-Weibliche
Zieht uns hinan.

(Goethe's *Faust*, Part II, final scene)

All transitory things are but parables:
The everlasting feminine leads us upwards to where the insubstantial becomes reality, where those things we cannot describe are done.

# Chapter 1

This Occasional Paper is in part a sequel to my previous work on the moral basis of general medical practice, *What is Good General Practice?* (Toon, 1994a) This was an analytic work in which I examined the intimate relationship between the judgements of fact and judgements of value that are implicit in all medical decisions. I argued that confusion between these two types of judgement and the grounds on which they should be made is at the root of many of the problems we face in making rational judgements about good practice. I then tried to analyse the models underlying different views of good general practice, concluding that we are faced with three competing theories of the nature of general practice, and hence of what it means to do it well. These make different assumptions about the nature of human personhood, the purpose of life and the place of medicine within it, and the nature and purpose of the doctor-patient relationship.

Although this book is a sequel to and will refer back to discussions in *What is Good General Practice?*, it is not essential to have read the previous work first. This summary and the introductions to each section should give the reader sufficient understanding of the argument of the previous work to make sense of this one.

The biomechanical theory is the core of Western medicine, and is often referred to as *the* medical model. The main assumption of this theory is that human beings are machines and doctors are human engineers. Mind and body are separated in Cartesian dualism. Illness, originating in the physical world, is an interruption to life to be externalized and removed with the least pain and effort possible. The values of the model are utilitarian. The prime purpose of medicine is the extension of life, the secondary purpose avoidance of pain and anything which may inhibit pleasure.

The anticipatory care theory shares these views, but takes the utilitarian values of the biomechanical view a logical step further. Traditional biomechanical medicine focuses on the individual patient who presents with a problem. Anticipatory care encourages doctors to focus on the health indices of the group of patients for whom they care. The theory emphasizes the desirability of prevention over cure, and applies the utilitarian arithmetic not just to the individual but to the population.

The principal difference between these theories and the approach which I referred to as hermeneutic-teleological, and which other authors refer to as interpretative (a more convenient label, which I shall adopt), lies in their model of human personhood. In contrast to the machine view of the biomechanic, interpretative theories have a holistic, humanistic view of human beings. The patient is a person with a life-plan, a life narrative. The doctor-patient relationship is I-Thou not I-It (Buber, 1994). Its purpose is to help the patient understand and integrate the illness into his or her life narrative, and where necessary to modify his or her life-plan to accommodate it. The Balint movement is the most obvious protagonist of this view in the UK, but many other writers on general practice share the same emphasis. For example, Brady (1987) speaks of the doctor as the clerk of the community; and Heath (1995) writes of the general practitioner not only as the interpreter but also as the witness of major life events in the patient's life.

*What is Good General Practice?* also considered whether family medicine and general medical practice were different concepts, concluding that they were not. There followed a brief exploration of the tensions between general practice as a business and as an altruistic moral activity. However, the agenda of unfinished business which (as in many academic papers) concluded *What is Good General Practice?* was mostly concerned with resolving the tensions between the three models of general practice outlined above. This is the main issue that will be pursued in this paper. It requires a satisfactory human ontology to reconcile the "man as a machine" model, on which biomechanical medicine is based, with the interpersonal holistic models of personhood implicit in the humanist understanding of the doctor-patient relationship. It also requires a system of values, particularly of the values of illness within life, which allows us to choose between them when necessary.

*What is Good General Practice?* deliberately kept to dispassionate analysis, in the academic tradition of the Enlightenment. Having analysed the various models, I did not explore the boundaries between them, nor did I attempt the more awkward task of putting them back together in a more coherent way. This work, in contrast, attempts to put the pieces together logically into a unified theory of general practice. This will involve applying some definite views of right and wrong which some, no doubt, will find unacceptable. However, I hope that the moral assumptions will be made explicit, so that if the conclusions are rejected the point at which the reader diverges from my view will be clear.

Before we can begin to tackle the agenda of unfinished work referred to above, we must establish the nature of our knowledge of facts and values. The distinction between these concepts was considered in *What is Good General Practice?*, but the basis of our knowledge in each area was not explored. This will therefore be our starting point (Chapter 2). I shall then consider the nature of the human being (Chapter 3) since a clear view of this problem is essential if progress is to be made on any other front. This section will be followed by a consideration of the nature of illness (Chapter 4) and of the role of medicine in relation to fundamental values about the nature and purpose of life (Chapter 5).

Before readers turn away to something more entertaining, like redesigning the blood pressure screening system, let me reassure them that it is not my intent to get bogged down in the muddy waters of epistemology or ontology. This is a practical work, not a piece of abstract philosophy. All that can be attempted in these few pages is to propound a reasonable position, not to establish an elaborate defence against all-comers. In each case, therefore, the approach will be to outline the issues briefly and propose a working hypothesis, rather than to attempt an in-depth justification that explores all possible criticisms and contrary points of view. Although many of these matters are relevant to all areas of human life, not merely to the practice of medicine, progress depends on remaining focused on the purpose of the discussion.

Once these philosophical foundations have been laid, it will be clear that a coherent model of good general practice must include not merely a deontological framework of what is right, but a virtue concept of what it is to be good. An integrated model of human personhood will incorporate the biomechanical model within the wider humanist perspective; it will also allow room for a view of the relationship between the internalization of sickness into the life narrative by interpretation, and its externalization by clinical action. For this to happen, we require a holistic model of right action.

The past few years have seen a great revival of interest in virtue within moral philosophy, and in medical ethics (Ellos, 1990; Pellegrino and Thomasma, 1993). I have suggested previously (Toon, 1993a, 1994) that virtue theory may offer a solution to some of the difficulties facing bioethics. The second purpose of this work is to test this hypothesis by attempting to apply the insights of virtue ethics to the particular problems of being a doctor in Britain as we approach the twenty-first century.

Since however, as Macintyre (1985) points out, we live in a society which seems morally pluralistic, any attempt to find a moral theory which will command a general measure of agreement has first to find a basis of moral agreement. Virtue, like rights, can easily be little more than organized prejudice. Arbitrary lists of virtues can be invented to justify whatever the writer happens to wish to promote. Failure to root virtues in a coherent meta-ethic makes such accounts seem capricious. Hence the importance of abstract questions of knowledge, the self, the nature of illness and the proper role of medicine, which may seem irrelevant to day-to-day practice.

It is equally necessary to consider the general nature of virtue (Chapter 6). Here, I shall offer a synthesis of various elements - Doyal and Gogh's theory of human need (1991) and Nussbaum and Sen's view of the virtues (1993), as well as the axioms adopted and the models developed in the preceding chapters. Macintyre's view of the virtues as cultivated within socially organized activities (Macintyre, 1985) will be the centrepiece of the structure. All that will be required is a little carpentry to fit the pieces of the jigsaw together. This is a rather presumptuous activity for an amateur philosopher to undertake, and I do so with some trepidation. However, since the task involves venturing into the no-man's land between philosophy, psychology and practical moral decision making, I can perhaps claim that as a professional in two of those three borderlands I am no worse qualified than most others to undertake it.

The specific nature of the virtues will be explored on the basis of a general view of the meta-ethical nature of virtue. Although conceived within a general framework, this investigation will apply specifically to British general practice, which will provide a 'case study' of the use of a general theory. The exploration of virtue will have three main elements. First will come some observations of the virtues required of the good general practitioner (Chapter 7). This will be followed by a discussion of another problem identified in *What is Good General Practice?* - our need for a theory of justice to reconcile the conflicting demands of different patients, and of patients' and doctors' needs (Chapter 8). Finally, I shall offer some suggestions on how these virtues might be cultivated in individuals, and on the structures within which such virtues will flourish (Chapter 9).

The reader may have noticed that although this work follows *What is Good General Practice?*, the wider term "medical practice" appears frequently in the above summary. Whilst my focus is general practice, much of what I shall say applies equally to other areas of medical practice. Precisely which parts apply to

which areas must be for others more familiar with those specialties to determine. However, general practice is not only the most common form of medical practice (at least in privileged countries like the UK) but also, I would argue, the prototype from which other specialties diverge. It therefore makes sense to start with this prototype.

Moral philosophy typically tries to address issues in a general manner. Medicine has traditionally advanced not only by this method but by the complementary approach of the case study - the detailed examination of the particular, from which one hopes to proceed to the general. This work, taking European general practice as its case study, may reveal insights relevant not only to European practice but to wider philosophical debate. As well as being an important area of moral discourse, medical practice provides a particularly apt testing ground for Macintyre's theory of virtue. One and a half of Macintyre's three examples of the incommensurability of contemporary moral discourse (1985; p.6) concern medicine and health. Medicine is prominent amongst the examples he cites when explaining his theory, yet in his earlier work (Macintyre, 1977) he argues clearly that there is no moral consensus in medical practice, and that doctors should advertise their moral values in the same way that they display their fees. We need to decide whether the state of moral confusion in our society is as great as Macintyre supposes.

A consequence of adopting this virtue approach to medical practice is that it opens up a large research agenda which is not merely philosophical but requires empirical scientific work. In the Postscript, this agenda will be outlined, and some suggestions made as to how we might tackle it.

# Chapter 2

# What can we know about facts and values?

The first task in *What is Good General Practice?* was to make clear the difference between facts and values. Factual statements link one state to another by an action, with no assumption about which state is to be preferred, whereas values express our preference for one state over another. It was important to be clear about this difference in order to analyse concepts appropriately in this subsequent work. The distinction is particularly troublesome in medicine, because many terms include statements about facts as well as assumptions about values. This is true of general terms, such as illness, disease, treatment and therapy, and also of the specific names of particular conditions, such as heart failure or depression (Toon, 1981).

The models of good general practice could be analysed without defining precisely what we can say about a fact or a value, and the relationship between the two concepts could be left open. However, if we are to construct a model which includes a satisfactory theory of personhood, sickness and the role of medical practice, we must consider this matter in more depth. This chapter will outline a view of the nature of theories of knowledge, and of what we can and cannot reasonably say about facts and values.

## Different views of knowledge

Attitudes to knowledge lie between two extremes. At one pole lies the radical sceptic, who doubts that anything can be known, with the possible exception of one's own mental existence. Even that, insofar as it exists over time, is open to doubt, since all past memories may be an illusion. Thus Descartes' (1637) view of human nature, his theory of dualism, is based on his famous axiom, "I think therefore I am." He concluded that he could be sure only of his thoughts, and on the basis of this epistemological belief he constructed his metaphysical theory.

At the other extreme lies the "common sense" position of one who takes everything at its face value, and has no doubts about the reality of appearances (Boswell, 1763). All is real, all is concrete, facts are facts, and there is no room for doubt or speculation. Such an attitude does not usually lead to a predilection for philosophical study.

Most scientists and philosophers of science hold a synthesis of these views. Whilst absolute certainty is impossible, and we construct our view of the reality that we experience, the construction we make is not arbitrary but is constrained by an external world which is in some sense real, even if we can never perceive it directly. In the last chapter of *What is Good General Practice?*, I quoted Einstein's image of the search for scientific truth as like climbing a mountain (Einstein and Infeld, 1938). As one goes higher, the view changes and becomes more complete. The relationship between sections of the surrounding countryside, which from lower levels could only be seen separately from different sides of the mountain, gradually becomes clear.

This image captures an important aspect of the nature of factual knowledge. We are explorers, seeking to piece together a map of the world in which we live by investigating it from different positions. In some areas, what we know is very clear and we have precise and robust theories. In others, near the boundaries of our theories, matters are less certain and it is not so easy to see how the separate areas fit together. To push Einstein's image a little further, it is as if we are climbing the mountain, not in clear sunshine but surrounded by clouds of mist, through which we see small patches with great clarity while other areas are blurred.

This is a useful way of looking at the search for truth, and much of the work which follows can be understood in these terms. Linking contrasting models of personhood, our different approaches to sickness and the role of medicine can be seen as ways of exploring boundary areas between the changing views we obtain by climbing higher up the mountain.

## Our view of reality is constructed not observed

Einstein's image of our exploration of the world is comfortingly pastoral. We make slow, often difficult, but steady progress up the mountain, and push back the frontiers of our understanding. Although it may always be incomplete, our knowledge of the world we perceive through the mists grows steadily.

However, there is another, more disturbing model of the relationship between different scientific theories (Toon, 1994b) - Kuhn's theory of scientific revolutions. Kuhn (1970) argued that this steady progress of "normal science" is periodically interrupted by radical changes when one apparently certain theory is replaced by a new one. This occurs when the amount of data

which the old theory cannot explain reaches a critical mass, and a new theory is proposed which can deal with this new material as well as with the data explained by the previous theory.

Paradoxically, despite his image of steady progress, Einstein's own work provides one of the best examples of such a revolution in science. He demonstrated that the apparently clear and certain world of Newtonian physics was merely an approximation, accurate in only a limited number of situations (including those in which we usually find ourselves, which is why Newton's theory has been so useful). When its limitations began to appear, however, Einstein needed not merely to climb a little higher, but to completely reassess what he was looking at in order to formulate a more satisfactory view.

Such scientific revolutions can completely upset our view of the world:

> *Nature and Nature's laws lay hid in night;*
> *God said "Let Newton be" and all was light.*
> (Pope, 1732)

> *It did not last; the devil, howling "Ho!*
> *Let Einstein be," restored the status quo.*
> (Squire, in Cohen and Cohen, 1960)

The occurrence in all areas of science of these "paradigm shifts", as Kuhn calls them, suggests that Einstein's metaphor is too simple. Better to imagine that we are looking down at night on something we had thought to be a road on the valley floor when we notice the moonlight glinting off its surface as we move, suggesting that it is not a road but a river.

## The uncertainty of knowledge

In science, theories are judged by how well they explain the observations made of the world. When two possible theories fit the data equally well, the simpler is preferred - the principle of Ockham's (1285-1347) razor (Honderich, 1995; p.633). Popper (1976) has argued that one can never prove a theory to be true, but only falsify it by producing evidence which contradicts something that the theory predicts. Thus truth is not absolute, but is a matter of probability. For example, to say that Boyle's law is true is to say that it is highly likely that the relationship which Boyle described between the pressure and volume of a gas is very close to the relationship which will be found in any future experiment.

Yet even this well-established law of physics is clouded by two niggling uncertainties. One is the faint suspicion that perhaps Boyle's law is not as universally true as it seems to be. For example, there may be some set of circumstances, of which we are unaware, which has ensured the truth of Boyle's law since 1650, but which will cease to apply tomorrow. This is highly improbable but logically possible. In the same way, the fact that the sun has risen every morning as far back as we can tell does not make it logically certain that it will rise tomorrow. Logically, even death and taxes are not absolutely certain. This is of philosophical importance, as it underlines that all our decisions and predictions are based on probability rather than certainty.

The second uncertainty lies in the precision of the relationship. Newton's Laws of Motion, for example, appeared to be a simple mathematical certainty until observations were made which did not conform to them. Einstein demonstrated that they were, in fact, approximations which hold under normal, familiar circumstances, but which are not universal. Any theory must similarly be seen not as an absolute rule but as a working approximation to the truth. If even simple, well-established laws in physics have this uncertainty attached to them, the degree of uncertainty which applies to complex biological, psychological and social systems will be much greater - perhaps large enough to have a noticeable impact not just in rare and abnormal situations but on the judgements we make in everyday life.

In this work, we shall mostly be considering macroscopic theories of which we are conscious or can easily become aware. Abercrombie (1960), however, in her important discussion of the psychological nature of judgement, points out that even the simplest observations involve the interpretation of data. She illustrates this with simple perceptual examples of different interpretations of data, making clear that our whole understanding of the world is based on such theories. In many cases, these interpretative theories are applied unconsciously, and we are unaware that we are interpreting at all.

## Theories are constrained by the world

This does not mean that we need to be nihilistic or relativist. The fact that we cannot be absolutely certain of anything does not mean that our knowledge is worthless, or that any hypothesis may be true. We all share a common human nature and inhabit a common world (at least, that seems to be the hypothesis which fits best with our experience). Some psychologists believe that the basic elements of the unconscious theories we use to make sense of the world are innate. Certainly, they develop very early in life, and since we all experience a similar world in many of its basic respects (gravity, sunrise, fires that burn and milk that

nourishes) then these elements too can be considered universal.

In the position I have outlined, all scientific theories are constructed to explain observations. The idea that we construct our view of the world, rather than its being a concrete reality which has to be exactly as we see it, is a central axiom underlying what follows. This is well illustrated in the psychology of visual perception. Everyone is familiar with "optical illusions" where the context misleads us into misinterpreting what we see; as for example in *tromp d'oeil* painting or the ambiguous figures popular in psychology textbooks. These demonstrate that perception is an active, not a passive, process.

The observations, however, are also important. We are not completely free to construct our theories in any way we choose. We construct them from a limited range of possible options, restricted by the data (and by the constraints of Ockham's razor). Again in visual perception this is shown by "impossible figures"; drawings that cannot be made into coherent depictions of three dimensional objects

We organize what we see in an attempt to make sense of it - a feature of human nature which Abercrombie (1960) refers to as the search for meaning. We can never be totally certain of what we see or experience, but our perceptions are constrained by an external reality.

A similar situation applies in clinical practice. If no one treatment is clearly the best amongst four or five available for a condition, we cannot assume that any possible treatment, or no treatment, is as good as any other. Quite often there is a small range of possible right answers, and it is hard to decide between them. A much larger range of answers are clearly wrong. General practitioners, trained in areas of science where statements can only be probabilistic, and used to dealing with uncertainty, will probably have little difficulty with this view.

## Theories may be complementary

Often, when two or more theories compete, only one can provide a satisfactory explanation of the observations we make. In other cases, theories are complementary, answering different questions or being useful in different circumstances. They look at various aspects of a phenomenon, like longitudinal and transverse sections of a three-dimensional solid. Thus a patellar hammer seems to the naked eye to be solid and static. Yet a physicist will tell us that it consists of tiny particles or waves of energy in constant motion, separated by huge areas of empty space.

We cannot say that one of these descriptions is true and the other false; they both tell us something true about the nature of the object. It could be conceived in other ways too. For the neurologist, a tendon hammer is a tool with a specific function; to the materials scientist, it has certain qualities of durability, flexibility and weight, which fit it for that function. An art historian may place its design in a historical and aesthetic context, whilst an economist may explain its features in other terms. If a simple inanimate object can be seen in such diverse ways, it is hardly surprising that interpretations of human nature are so varied.

This view of truth does not mean we can say that there is some truth in every view - a sort of mindless and uncritical eclecticism or relativism. This would be to ignore the constraints of external reality. Furthermore, there is value in seeking to link different aspects of truth. Such an approach helps to avoid seriously distorted views, and is a step further towards the distant goal of integrating our fragmented theories into one completely satisfactory and comprehensive theory. For example, all students in science learn of the discovery of the separate laws governing the behaviour of gases - those of Boyle and Charles, and the Law of Pressures. These were soon combined as the gas equation. Similarly we see different aspects of our understanding of human nature coalesce into a more unified theory. Thus in psychology, various theories of psychoanalysis (Stafford Clark, 1965) and of human nature (e.g. those of Skinner, 1969) at one time seemed to be mutually exclusive rivals. Yet many of the very different phenomena that each of them explained are now satisfactorily dealt with in cognitive-behavioural psychology (Phares and Trull, 1997), a theoretical framework which draws on both traditions, particularly as it develops to bring within its scope schemata central to personal identity as well as more superficial aspects of human behaviour.

## Kelly's epistemological framework

A helpful formulation of this view of knowledge as constructed but yet constrained by a real world was produced by George Kelly (1955) in his "personal construct theory". He also developed a useful vocabulary to talk about it. Kelly argued that the scientific method is not just a methodology for one area of human knowledge, but a model for all human psychological functioning. In his view, "man is a scientist" whose "psychological processes are channelled by the way in which he anticipates events." We construct theories in order to understand the world, mainly so that we can make predictions about what is likely to happen in similar situations as a result of our own actions, those of others, or those of nature.

He suggested that a useful way to describe theories is in terms of a set of related dimensions defined by opposites at each extreme: good-bad, soft-hard, light-dark, friendly-hostile are examples of such "bipolar constructs". The things which we categorize by placing at different points on such bipolar constructs Kelly referred to as elements. Different constructs are appropriate for different elements. Thus we might categorize people as good-bad, friendly or hostile; whilst we might use soft-hard, light-dark to "construe" building materials.

In understanding our theories or construct systems, the relationship between different constructs is important. They may be independent, as in "soft-hard, light-dark" (such constructs are orthogonal, or at right angles, in his technical jargon, which pictures construct systems as existing in multidimensional space); or they may be closely related and highly correlated. Some people may use good-bad and friendly-unfriendly to construe people in this way.

Kelly was a psychotherapist, and understanding human behaviour in those seeking psychotherapy was the main purpose (in his terminology the "focus") of his theory. If we equip our mountaineer with a telescope, the focus is the point on which the centre of the lens is trained. However, telescopes do not point only at one object: they offer a field of view. Similarly, theories are useful over an area. Kelly called this the "range of convenience" of a theory. Just as lenses tend to focus less sharply or to distort at the periphery of the field of view, so theories are less useful or less precise when they are used to construe objects near the periphery of their range of convenience.

Kelly pointed out that many theories in psychology could not explain the behaviour of the person constructing the theory. One of the claims that he made for his theory, and one which he believed made it superior to many others, is that it includes within its range of convenience the actions of the person constructing the theory. He used the term "reflexive" for this type of theory (just as reflexive verbs can refer to the actions of the speaker). Such theories, he argued, were both logically and evaluatively superior to those where the observer stood outside the theory. Because doctors, like patients, are human beings, we will find the test of reflexivity important in the chapters which follow.

Although designed primarily as a framework for a psychotherapeutic approach, Kelly's theory provides a useful set of terms for a wider discussion of epistemology. The concepts and terms he defines will be used freely in the discussions which follow.

## From facts to values

A key thesis of *What is Good General Practice?* was the importance of being clear about facts and values. These are frequently confused in medicine, partly because many of our concepts (e.g. names of diseases) are both factual categories and value judgements. A decision between two theories of facts can be made on the basis of data - a procedure currently promoted as evidence-based medicine. Such decisions, however, imply nothing about which of two states is preferable. To assess this requires an evaluative decision. Frequently, people try to adduce factual evidence to support their evaluative judgements, although the converse error is also possible.

## Moral relativism and subjectivism

To insist on the distinction between facts and values, often referred to as the "is-ought" distinction, is often taken to imply that these are totally unrelated, a view summarized in the statement "one cannot derive an 'ought' from an 'is'" (Hannaford, 1972). The belief that one can is criticized and labelled the naturalistic fallacy (Moore, 1903). Hume (1740) is widely thought to have made that point, although some argue that it is the surreptitious and unconscious moving from "is" to "ought" that he criticized, not the possibility of doing it at all, and that he himself did base "ought" on "is".

The distinction is also commonly assumed to imply that moral judgements depend on culture and are relative, and that therefore we cannot validly make judgements about moral values in cultures other than our own - a view known as relativism. This belief has a wide but often uncritical following. Subjectivism, the view that one cannot make moral judgements for anyone else at all, and that individuals can only determine their own morality, is a more extreme version of the same idea.

Macintyre (1985) argues that prior to the Enlightenment there was a coherent moral tradition in Western society. The radical scepticism of the Enlightenment, mentioned above in relation to Descartes's epistemology, shattered that tradition, and our discussions take place from different standpoints, each of which is a fragment of that tradition. It is as if victims of a shipwreck were shouting at each other from different pieces of flotsam, each believing that they were on the ship. Macintyre is pessimistic about our hopes for coherent moral discourse. It will require "a new and doubtless very different St. Benedict"(1985; p.263) to bring order out of the current chaos.

In *What is Good General Practice?* I concluded that the three principal models of general practice appeared morally and epistemologically incommensurable, as if they were different parts of Macintyre's fragmented post-Enlightenment universe. Some readers therefore deduced that it was written from a standpoint of moral relativism, although this was not my intention.

## Emotivism

Linked to relativism, and making it seem more credible, is the view that moral judgements are matters of feeling or emotion - hence emotivism. The philosopher G E Moore (1903) is associated with this view. He compared moral judgement with aesthetic perception: one cannot say why something is beautiful or good, one just feels that they are. From accepting that moral judgements are matters of feeling, it is a small step to believing that they are "nothing but" matters of feeling, and that therefore:

- They are matters that cannot be subjected to rational argument.
- Every person's judgement on these matters is as good as anyone else's.

The jump from arguing that moral judgements are essentially matters of feeling to saying that they are nothing but matters of feeling is similar to the position of extreme behaviourism taken by the logical positivist. From the reasonable view that we can have firmer evidence of behaviour which can be observed in the external world than of thoughts and cognitive structures which cannot be directly observed (methodological behaviourism), they jump to the conclusion that nothing but behaviour is of any importance, and that anything which cannot be directly observed is of no importance or value (radical behaviourism). A similar jump is sometimes made by those who support the currently fashionable emphasis on evidence-based medicine. It is a small but logically dubious jump from seeing the evidence of controlled trials as the soundest evidence on which to base clinical actions to the view that there is no other valid evidence for medical activity. Although logically false, "nothing-but" jumps are widespread both within medicine and in society at large.

## Relationship between relativism and emotivism

Although often held together, relativism and emotivism are not logically interdependent. Aesthetic judgement is often seen as a subjective matter, in which no-one's view is better than any other - "I don't know much about art but I know what I like." There is, however, a defensible absolutist view that beauty is not merely in the eye of the beholder but is an objective feature of the world. There may be argument at the edges (about the merits of avant-garde sculpture and radically innovative buildings, for example), but hundreds of thousands of people from all cultures make considerable efforts to visit buildings and to see works of art universally agreed to be of great beauty - the Taj Mahal, Canterbury Cathedral, the Great Mosque at Cordova, the Venus de Milo, the Leonardo Cartoon. Art historians and experts in composition can demonstrate how these pictures and buildings make their aesthetic impact - the golden section, the subtle blend of balance and asymmetry, the mathematical properties of harmonies, patterns of discord and resolution - in ways which depend on the nature of the world and our fundamental humanity.

Just as one can see aesthetic judgements as both emotive but also absolute, one can consider moral views as emotive and still believe absolute values to be possible. Similarly, we cannot assume that theories about facts are immutable and based only on reason. In both empirical and evaluative matters we have to judge why we prefer one theory to another. We cannot simply equate values with subjectivity, and facts with objectivity.

## Moral consensus

Some moral philosophers argue convincingly that relativism is false and Macintyre's pessimism is unjustified. Midgley (1981, 1991) launches one of the best-argued attacks on relativism and emotivism. The account below draws heavily on her work. She sees relativism as an error based on an exaggerated tolerance of other people's views.

Tom Lehrer (1959), in the introduction to one of his songs, remarks that the US army has taken equal opportunities to its logical conclusion in outlawing discrimination on grounds not only of race, religion and sex, but also of ability! Two quite different sorts of discrimination are involved here. Race and sex are irrelevant to the distinctions which the army has to make in selecting individuals for different ranks and functions, and discrimination on those grounds is prejudice, which we condemn. In contrast, making appointments on the grounds of ability is discrimination in the sense of discernment, which accords with justice and is to be approved.

Midgeley suggests that we similarly confuse legitimate and unacceptable moral judgement because, historically, in our society too many unjustified judgements are made. Being unnecessarily judgmental of others is an unwise and often hypocritical practice (The Bible; Matthew 7: 1-5), and not making moral judgements when we do not have the information on

which to make them fairly is commendable. However, as in Lehrer's example, this can be taken too far. We should be confusing tolerance with negligence if we thought that the prohibition of murder was just as much a matter of personal preference as a taste for whisky rather than gin.

Midgeley points out that all moral positions, including relativism, rely on some form of moral judgement. Saying that one ought not to make moral judgement about other cultures is itself a moral judgement, usually based on a value that one should respect the autonomy of others' positions. To claim that one must not make moral judgements is as self-contradictory as the famous paradox that "all absolute statements, including this one, are false."

Moreover, when we examine the matter more closely, such tolerance is highly selective and subject to fashions of political correctness. This can sometimes amount to nothing less than hypocrisy. In India, it is common for female fetuses to be selectively aborted after ultrasound scanning (Toon, 1993b). This is widely condemned. Those outside India who do so place the principle of sexual equality above respect for other people's culture. Yet these abortions could be seen as analogous to those for handicap in the UK, which many of those same people approve on the grounds of "the woman's right to choose". Within the cultural groups in which the practice occurs, being female is a serious handicap - and an expensive one for a family that has to support daughters and provide them with large dowries when they marry. Lacking a Y chromosome in rural India may be as great a handicap and strain on the family as having an extra 21 chromosome in a London suburb, and abortion makes just as much pragmatic sense. One important function of philosophical analysis is to reveal such inconsistencies.

Midgeley points out that it is in any case illogical to suggest that values can take different forms in different cultures. Cultures are not hermetically sealed entities with no contact between each them, but networks of individuals with slightly different sets of attitudes. How do we define the boundaries of a cultural group? Fuller's map of the individual surrounded by family, subculture and culture (Figure 1) is a better model of cultural diversity than a compartmentalized view.

This is not to say that there are not real differences between what is seen as right and wrong in different cultures, but that when we examine these variations carefully we often find that they do not reflect differences in intention, but in perceptions of how to achieve the same end. Midgeley (1991) gives the example of a story by Herodotus about how one should treat the dead. In one culture, it is considered quite wrong to burn one's parents' bodies since one should eat them; another views eating them with horror, and would be appalled at anything other than cremation. These two conflicting attitudes, however, reflect a shared concern to show appropriate respect to the dead bodies of one's parents. This common moral foundation is linked to fundamental human relationships.

We have to seek a coherent basis for our judgements, and an equally coherent basis for refusal to judge. Midgeley argues that this lies in absolute values rooted in our common humanity and the nature of the world. There are some fundamental moral values without which any form of corporate life would be impossible. Her example is the rule that one should keep one's promises. Without this principle, we could have no money, no bank accounts - no trade at all other than the most basic barter. Employment would be impossible, as would the provision of gas, electricity and piped water, since these rely on the water company's promise to supply the utility and the consumer's promise to pay for it. Taxation and public service would also fall apart.

These examples apply to a modern Western civilization, but similar practical problems would exist in any human culture. To see this, one only has to consider totalitarian societies in which lying became a normal part of public life. The examples of Nazi Germany and Soviet Russia show that in the long term a society based on falsehood is unsustainable. Similarly, when prohibitions on violence break down life becomes intolerable - as we have seen only too clearly in Bosnia and Rwanda. Whilst individuals may

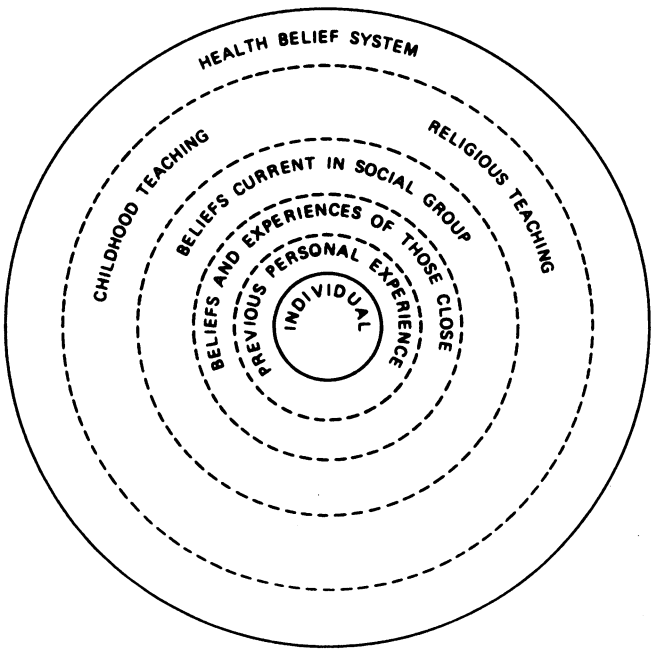


*Figure 1*

get away with a sustained programme of evil-doing in the short and even long term, a whole society run on that basis is unstable.

It is in this testing against external reality that relativism fails. Just as the Copernican universe works better in a number of practical ways than that of Ptolemy, so a value system which endorses keeping promises is better than one which leaves the matter to personal preference. Boswell might have been correct that one cannot refute Berkeleyism by intellectual argument, but Johnson was surely right that it fails when we kick the stone of everyday life (Boswell, 1791). Relativism too, like creationism and solipsism, fails this practical test.

This view will inform the rest of this work. As with facts, so with values: we cannot expect to discover ultimate and absolute truth. On the other hand, we do not have to abandon ourselves to a totally pessimistic relativism. We must go forward on the basis of such certainty as we can reasonably achieve, and make empirical and moral judgements, even though these will always be provisional.

# Chapter 3

# Two models of a human being

The three competing theories of general practice defined in *What is Good General Practice?* use two different models of the human being. If we are to reconcile these theories, our next task is sort out the relationship between these models.

## Biomechanical and humanist models

The model of the biomechanical theory is that human beings are machines and doctors are human engineers. Mind and body are separated, as in Cartesian dualism, and illness occurs in the physical realm, where determinism reigns. The anticipatory care theory, although differing in some other respects, shares this view of human beings. In contrast, hermeneutic or interpretative theories have a holistic, humanistic view of human beings. The patient is a person with a life-plan, a life narrative. The doctor-patient relationship is I-Thou, not I-It (Buber, 1984). The main differences between these two models of human personhood are summarized in Table 1.

***Table 1*** Principal differences between biomechanical and humanist models of human selfhood.

| | *Biomechanical* | *Humanist* |
|---|---|---|
| *Nature of human being* | Machine | Person |
| *Doctor's role* | Engineer | Friend, pastor, guide, witness |
| *Nature of causality* | Determinism | Free will |
| *Relation between mind and body* | Dualist | Holistic |
| *Doctor-patient relationship* | I-it | I-thou |
| *Values* | Hedonic | Interpretative |
| *Illness* | Externalized | Internalized |

## Relationship between the two models

As when any two models appear to conflict, the first task is to examine their relationship. Are they competing or complementary? Do they have similar or different foci and ranges of convenience? In Chapter 2, we noted Abercrombie's (1960) use of visual images to illustrate the nature not only of perception but of all knowledge. Another visual image (Figures 2 & 3) may clarify the relationship between the biomechanical and the hermeneutic, or teleological, models of the human person. The biomechanical model bears the same relationship to the hermeneutic model as the line diagram does to the photograph. The diagram omits much of the richness and the information of objects, their texture and shade which we see in the photograph. Yet it is more useful if we wish to understand how the picture works, how the photographer has composed the picture, using lines to lead the eye, and shapes and balanced masses to give a satisfying effect.

So it is with our models. The biomechanical model is a useful simplification, which has enormous practical value in helping us to understand how the body works and how to treat disease. It has succeeded better than any alternative model in this task, which is its focus.

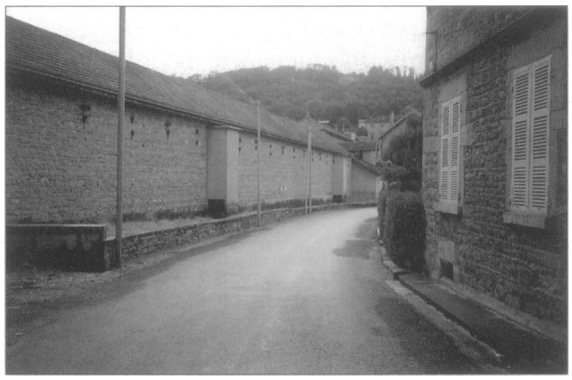

*Figure 2*

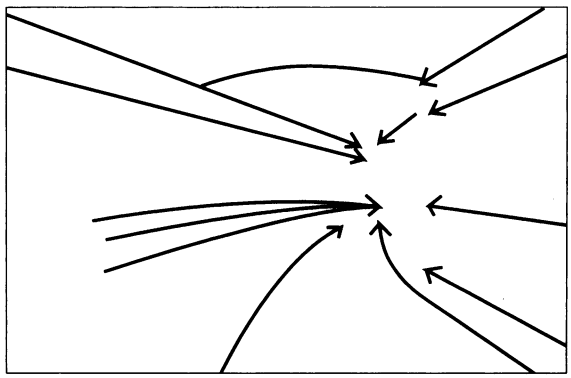

*Figure 3*

Some of its rivals, such as the humoral theory of disease, have been completely superseded by it as a result of a Kuhnian "paradigm shift", and are almost forgotten. Others, such as the Chinese model of lines, energy and forces, which underlies acupuncture and some other traditional Chinese treatments, are useful in some situations which lie outside the range of convenience of the biomechanical model. It is, however, a model - a simplification which does not include the whole of reality.

The humanist model is in many ways richer, with a wider range of convenience than the machine model. It enables us to live in a lush world of feelings, emotions and personal relationships which lie beyond the scope of the machine model. To attempt to use the biomechanical model beyond its narrow range of convenience in the analytic aspect of medical diagnosis and prognosis is to risk falling into serious error. We do this frequently when we forget that patients come to us as people to be healed and not just as bodies to be mended. It is common to talk of consultations as doctor-centred or patient-centred. It might be more helpful to think of them as using predominantly the machine model or the humanist model.

We can take our visual metaphor a little further. Although the oil painting provides a richer image than the line diagram, it still does not fully describe the scene. The world which the painter saw had other dimensions - sound, scent, changes in light, and three-dimensional space - which do not appear in the painting. Similarly, the humanist model of the human being has its limitations. Neither of the models is complete. Indeed, as the last chapter demonstrated, no model can be since all theories are provisional. But this does not mean that models are of no value; if anything, it may make them more useful. A map has to select and therefore omit information if it is to be useful. If it does not, it is not a map but a copy of the place it represents. As such, it is of no help to us. We need different maps for different purposes, but we need to know the values and limitations of each map.

Both models have their particular limitations. Commonly used versions of the humanist model have important inadequacies that are not just loose ends of abstract philosophy; failure to understand them properly can lead to confusion in medical practice. The remainder of this chapter will consider the limitations of both models, and explore some of the difficulties we encounter if we fail to recognize these and attempt to push our models too far.

## Sit lightly on your models

We can easily become over-attached to our models, and ignore evidence which does not fit within them. Kuhn (1970) points out how this can happen in the community at large, in relation to scientific theories. In clinical practice, it can also happen in individual cases. Clinical decision making always involves accepting certain pieces of evidence as important and ignoring others as irrelevant (McWhinney, 1981). A doctor too used to the biomechanical model may reject important data, such as a patient's feelings, which do not accord with that model. There are countless instances of this, as doctors by their training tend to be overly biomechanical. The converse can also happen, however; a doctor who views problems in terms of the patient's understanding and personal relationships may fail to interpret correctly evidence of a problem which could be well understood and addressed in biomechanical terms. The following case illustrates this:

*A young man recently diagnosed as having AIDS registered with a new general practitioner. The patient was having great difficulty dealing with this diagnosis, and became seriously depressed. As well as prescribing antidepressant medication, the doctor spent a number of consultations exploring his feelings about his illness.*

*A major difficulty for him was telling his family, which he knew would be necessary on his visit to them for Christmas. After his return, he visited the doctor to tell him that on the way to see them he developed a severe headache which had continued intermittently ever since. The doctor concluded that the headache was due to the tension arising from this difficult family relationship - a view which the patient accepted.*

*The headache persisted for two or three weeks, if anything getting worse rather than better. The patient remained distressed. It was only when the patient became confused that he was taken to casualty by a friend. The casualty doctor, unaware of the interpretative aspect of this patient's problems, adopted a biomechanical approach and ordered a CT scan. This revealed evidence of an intracranial mass. Brain biopsy revealed an opportunistic fungal infection which, fortunately, was successfully treated.*

## Limitations of the machine model

Although the biomechanical analogy is useful, its reflection of clinical practice is inadequate. We do not need to look to psychogenic problems for instances of this; even in the most obviously physical illnesses and injuries, the human body is much more active in self-healing than any machine. There can be few more straightforwardly mechanical problems than a fractured bone, and few doctors more inclined to a mechanistic approach than traumatologists. Yet the role

of the surgeon is quite different from that of the welder mending a broken steel spar in a machine. Without the welder, the spar will remain broken forever; but the osteoclasts and osteoblasts will do their work, repairing and remodelling the bone, whether the surgeon intervenes or not. The role of the surgeon is crucial: without proper reduction and splintage, healing is likely to be more painful and less satisfactory. It is, however, a managerial role - directing, monitoring and adjusting natural healing processes, rather than performing the repair. Similarly, immunizations stimulate the body's own defences, and antibiotics support our immune system in fighting infection. As cases of congenital and acquired immunodeficiency illustrate, antibiotics can only reinforce, not replace, these natural forces.

## Limitations of determinism

Determinism is the philosophical belief that every event has a sufficient antecedent cause, which in principle, if not always in practice, can be known: in Einstein's memorable phrase, "God does not play dice." This is a useful working hypothesis in science and many other activities. It enables us to make predictions and perform experiments which add to our understanding of the world. But it has its limitations. Einstein's remark was made when it was suggested that in physics at the atomic level determinism does not apply (Stewart, 1989). Much of modern physics is based on the recognition that in this case Einstein was wrong.

Determinism is also an unsatisfactory hypothesis in our relations to other people as persons rather than objects. Perhaps the best illustration of the unpleasant consequences of taking determinism too far in relation to human behaviour can be seen in the philosophy of B F Skinner, set forth in his picturesque (and chilling) utopia, *Walden Two* (1948), which many would see as a dystopia, and more academically in *Beyond Freedom and Dignity* (1971). Skinner suggested that by applying the behavioural principles of conditioned learning, which he did much to elucidate, human beings could be brought beyond the suffering and inconveniences which arise from what he sees as a mistaken attachment to freedom and dignity.

Psychological evidence suggests that Skinner's beliefs are empirically false, and that more complex models of learning are required to predict and control human behaviour. Furthermore, as Abercrombie (1960) points out, human beings are resolute in their pursuit of meaning as well as of physical pleasure. Even if this were not the case, there are evaluative reasons for rejecting a Skinnerian brave new world. There is, perhaps, no means of proving that Skinner's value system is wrong, but if the reader wishes to seek a Skinnerian paradise we must part company at this point.

There is also a logical problem with the determinist approach to human behaviour. This follows from Kelly's point that satisfactory theories must be reflexive. A theory based on a chain of conditioned reflexes has no place for the cognitive processes of the theorist, and therefore fails to explain Skinner's own behaviour, which seems strongly driven by a search for meaning. Although determinism is a useful assumption in the biomechanical model for making treatment plans and performing surgery, on the whole it seems better to conduct our doctor-patient relationships on the assumption that we are both free agents who can make and implement choices.

## Limits to freedom

There are limits to our free will which humanist models do not always sufficiently recognize. Many aspects of our selves, both physical and psychological, are beyond our conscious control. We do not always act as completely free agents. We are constrained by hereditary, physical and psychological limitations, and by our social situation. There are limits to our natural abilities. No one by thought can add a cubit to their height (The Bible; Luke 12: 25). No matter how hard I practise and how much I might wish to, I shall never be able to sing Wotan in *Die Walkürie*, or win an Olympic Gold medal for cross-country skiing. Midgeley (1991) points that Sartre's famous young man, faced with the choice between joining the resistance and fighting for his country, and caring for his aged dying mother, was faced not with a blank sheet in which any option would be good, but with a narrow choice of good actions and a larger choice of bad actions - including abandoning his mother for a life of pleasure, and collaborating with the enemy.

## The boundary is not clear

Such a view of volition is not new, of course. St Paul understood this: "The Good which I want to do, I fail to do; but what I do is the wrong which is against my will" (The Bible; Romans 7: 19). This phenomenon, often referred to in philosophy by the Greek term *akrasia* (Charlton, 1988), usually translated as weakness of will, is an important aspect of human nature which our models must take into account.

We can only reasonably be morally obliged to do things that are within our power: "ought" implies "can". Our range of choices is limited by our habits, our abilities and our previous actions. Someone who is restricted by a phobia, or who finds it necessary to spend a large amount of time on obsessional checking

rituals, does not feel their avoidance of the feared object or their compulsive behaviour to be voluntary, and would prefer not to do it. When given suitable advice and support, they can choose to take part in a treatment programme which will free them from these restraints. Are the phobic avoidance and obsessional rituals voluntary or involuntary? Neither designation is fully appropriate; the truth is somewhere in between.

## Limitations of dualism

Clinical practice takes us into areas beyond the range of convenience of the dualist assumption of the biomechanical model. The focus of medicine is the body and the physical, and the machine model often seems to exclude the mental from consideration completely. Sometimes this approach works quite well, but often it fails. One of Balint's (1957) great contributions to general practice was to point out how frequently factors in our emotional and social life cause our physical symptoms; many other workers in psychosomatic medicine have compiled convincing scientific evidence that this is so (Hill, 1976). However, since the biomechanical model is dualist we find it hard to integrate this evidence into our practice. "We" in this case means both doctors and patients, for many patients bring to the consultation a rigidly dualist model of their own self.

It is not necessary or appropriate to explore the complex metaphysics of mind-brain relationships here, but we must recognize that a rigid dualism is unsatisfactory. The concept of overlay (still widely used, especially in specialist practice) is inadequate for dealing with the reality of the unity between the physical and the psychosocial. We need ways of understanding how social and emotional factors affect physical health, and how the physical functioning of our bodies affects our interior and interpersonal life.

## Limitations of the humanist model

In contrast with the biomechanical model's overemphasis on the physical, a problem with most humanist models is that they are too idealist. So prevalent is dualism in our society that those who emphasize the interpretative model often neglect the body. Few humanist concepts of personhood take bodies seriously. Balint *talks* about the pathology of the whole person, but what he often seems to mean is the pathology of the whole mentalistically conceived personality. We are trapped into an either/or mind-body dualism, and it is hard to get the balance right.

Almost by definition, it is difficult to persuade philosophers to take bodies seriously. They spend large amounts of time cultivating their minds, often giving comparatively little consideration to their bodies, so this prejudice is psychologically quite understandable. We know that the Greeks valued physical excellence from the high value they placed on athletic activity, but philosophers tend to ignore it. Thus, Aristotle has much to say about intellectual and moral virtue, but almost nothing about physical virtue. In our society thinking on moral issues has been strongly influenced by Christian thinkers, who, despite orthodox condemnations of these opinions, have sometimes been overinfluenced by the idealist heresies of Manicheism (with its notion that the soul is good and the body evil) and docetism (which regarded Christ's human body as an illusion).

It is hardly surprising therefore that medicine, which takes the body intensely seriously - and which in the biomechanical theory tends to take nothing else seriously - has such difficulty in embracing holistic concepts.

## Limits to rationalism

An adequate concept of personhood demands that we take our bodies seriously, but we are equally required to take the minds of both doctor and patient seriously. This means accepting that both are rational beings, capable of making coherent and rational judgements, and ideally working together to do so. But it also means accepting that our psychic make-up is much more complex than rationalism assumes. We have unconscious desires and needs. Transactional analysis (Berne, 1966) views all human beings as containing an adult (Kant's rational will), a parent (akin to Freud's superego) and a child. We may wish to develop the adult-adult relationship, but we must recognize the existence of the child and the parent in both doctor and patient. Perhaps the greatest contribution of Balint to our general practice tradition is not, as Hart (1968) suggests, the recognition that patients have hidden needs, but the recognition that doctors have them too. We need to grasp the therapeutic importance of events which happen at that level, both for good and for bad.

## Boundaries of the self

In both the physical and the psychological world, our selves interact with the world around us. Psychologically, who we are is deeply affected by our relationships, and it is sometimes hard to know precisely where the boundaries are - an insight which forms the basis for family therapy. Our physical bodies are similarly affected by the food we eat and the drugs we take. Even the distinction between these two categories of substance is fuzzy, and the UK requires a Committee on Borderline Substances to draw it.

The moral implications of the disposal of toenail clippings are unproblematical, but how we treat more significant parts of the body when they have to be separated surgically can be important. The effect on our personhood of what we put into our bodies is also important. Is it "me" that is altered when I drink alcohol or take psychotropic drugs? This raises important questions about responsibility.

## Determinism, self-control and responsibility

We encounter problems not only when we attempt to push assumptions like determinism and dualism beyond their range of convenience, but when we make excessive assumptions about the relationship between these and other concepts. It is often assumed that dualism, determinism, responsibility and voluntary control are indissolubly linked, usually through the notion of free will.

The argument, although rarely stated explicitly, seems to run as follows. If an action is under voluntary control, so that the individual can choose to do it or not to do it, then the choice made is the responsibility of that individual. Conversely, if an action is involuntary and an individual cannot choose whether or not to do it, then the individual is not responsible for the action or its consequences. Volition, guilt and responsibility lie in the mental sphere, whilst lack of guilt, determinism and freedom from responsibility lie in the physical. Furthermore, it is presumed that understanding the causes of a certain behaviour, and being able to predict it, puts it outside the control of the individual who does it, and therefore frees that individual from responsibility. These dimensions - physical/mental, free/determined, responsible/exempt from responsibility - are used as if they were synonymous. In Kelly's terminology, they are constellatory constructs (Table 2).

***Table 2*** The constellatory constructs concerning free will and responsibility used to construe acts.

| | |
|---|---|
| Physical | Mental |
| Determined | Free |
| Involuntary | Voluntary |
| Not responsible | Responsible |
| No guilt | Guilt |

The link of freedom, responsibility and guilt to the mental sphere, and of their opposites to the physical sphere, then tends to associate them with the two models. The characteristics in the left-hand column of the table are thus associated with the biomechanical model, and those on the right with the humanist model.

In clinical practice, however, we have to shuttle between the two models, and it would often be more helpful to take constructs from both spheres; for example, to be free from guilt for something for which one nevertheless accepts responsibility, or to believe that something for which one is not responsible is nevertheless under voluntary control. An important difficulty which flows from this constellatory use of constructs is the distinction between mental illness and criminal or immoral behaviour (the mad/bad dichotomy), and how we should deal with the associated problems of guilt.

## Mad or bad?

The mad/bad distinction says that either a person is bad, in which case he has chosen to act as he did, is responsible for his actions, and deserves to be punished; or he is mad, in which case he could not but act as he did, is not responsible for his actions, and deserves pity rather than blame. From responsibility flows blame, if the action is wrong, and also guilt, which is the emotion which arises when one blames oneself. The converse is similarly assumed to be true: if an action is not under voluntary control, then its consequences are not the responsibility of the agent, and there is no blame or guilt (Table 3).

***Table 3*** The constellatory constructs comparing 'mad' and 'bad' used to construe acts.

| | |
|---|---|
| Bad | Mad |
| Voluntary | Involuntary |
| Responsible | Not responsible |
| Blame | No blame |
| Guilt | No guilt |
| Punishment | Treatment |

"Guilty" and "responsible" are commonly used as synonyms, although the legal verdict "guilty but insane" illustrates that they are separate concepts. This demonstrates the importance of distinguishing guilt as a matter of causal fact from guilt as an emotion.

In terms of the mind-body dualism, the 'bad' act arises from the person's mind, which he can control, whilst the 'mad' act arises from his brain and is beyond his control: he requires chemical treatment rather than punishment. This dichotomy assumes that a clear line can be drawn between voluntary and involuntary actions, responsibility and no responsibility, guilt and innocence, mental and physical; and that the line in general falls in the same place.

On reflection, these assumptions are gross oversimplifications. The voluntary/involuntary distinction is better thought of as a continuum than as a dichotomy. Similarly, guilt and responsibility are usually not absolute, but are matters of degree. Mental and physical are inextricably intertwined, and there are cases where the three constructs are best used independently rather than as a bundle.

## The need for a dynamic concept of autonomy

Autonomy has become a buzzword in medical ethics. For Beauchamp and Childress (1989), it is one of the four core values of medical practice. The promotion of autonomy has been at the centre of the attack led by a recent generation of non-physician medical ethicists and patient representatives on the arrogance of medical paternalism. The rise of bioethics has largely mirrored the growing importance of respect for autonomy (Pellegrino and Thomasma, 1988).

The heartland of the autonomy debate has been the USA, reflecting the cultural assumptions of that society. Autonomy as generally understood has its roots in liberal capitalism and a tradition of moral theory dating from the eighteenth century, most notably rooted in Kant. As an Enlightenment notion, it arose in a world where individual choice and personal freedom were frequently violated. It was designed as a weapon in the fight against autocracy; and was a tool of the French and American revolutions. As such, it has served well in the fight to liberate the patient from the paternalistic autocracy of the doctor, particularly the biomechanical doctor; this fight has been conducted on similar if less bloody lines to those characterizing the revolutions just mentioned, again particularly in the USA. There it has led to results which many doctors and patients see as undesirable, even if less extreme than the Directoire or the Terror.

A breakdown in trust and a litigious, confrontational attitude between doctor and patient has led to astronomical medical defence costs, and to doctors practising unhelpful and expensive defensive medicine. In the most extreme cases, doctors have retreated to offering merely technical advice on available options, refusing to express a preference lest they impinge on patients' autonomy. Pellegrino and Thomasma (1988) have argued that this process has gone too far, and that beneficence needs to be reasserted as a core value in medical practice.

In Europe, we have not reached this sorry state. Despite increasing strain, particularly evident in Britain since the promotion of the consumerist-business model through the Patient's Charter and the Internal Market, most doctor-patient relationships continue to be based on trust and mutual respect. Indeed, advocates of increased information and patient involvement in decision-making would still be concerned that medical paternalism is alive and kicking. However, the situation described by American writers does suggest that the solution to paternalism may not simply be more autonomy.

From its roots in the Enlightenment, the concept of autonomy is intensely rationalist. Enlightenment man (sexism being a post-Enlightenment concept) is a disembodied rational spirit, a will to which emotions and a body were unfortunate but necessary adjuncts. Cartesian dualism is part of this intellectual package. Thus, the autonomous human being whose choices need to be respected is such a rational being.

The autonomous patient is most clearly seen making a free and informed decision about a choice of treatment, one which can be taken coldly and clearly, without haste, and in a state of emotional detachment - as an Oxford don might rationally weigh up the options in deciding which sherry to buy. Autonomy, here, is a strictly mental concept, with no impact on the body.
Liberal capitalism also arose in the same eighteenth-century intellectual climate. It is therefore hardly surprising that autonomy comes to be seen as a personal possession, and respect for autonomy as a species of respect for property rights - particularly in that bastion of capitalism, the USA. Thompson's (1971) entrancing paper on abortion, for example, applies property right concepts to the way in which women choose to control their own bodies.

We have seen (Toon, 1994a) how for the biomechanical doctor it is possible to shift from paternalism to respect for autonomy without any significant impact on the model as a whole. This follows from the rationalism and dualism of the conventional notions of autonomy. Since the biomechanical doctor has a dualistic notion

of the body and a rationalist notion of the relation of the doctor to the patient, there is no need to make any significant changes to the model. Patients have always been rationalist, autonomous agents up to the surgery door. Now, rather than parking it outside, they bring their autonomy into the surgery with them. For the consumerist, another rationalist model, this conventional notion of autonomy is similarly unproblematic. Indeed, consumerist patients are autonomous patients par excellence, making unfettered choices in the marketplace in accordance with their free will.

This negative "keep your hands to yourself" notion of autonomy is less helpful in other models. For the prevention-centred doctor, the same difficulties arise with respect to autonomy as face any utilitarian. If the greatest good requires some people to act against their wishes, how does one resolve the conflict? In general practice, the problem does not arise with the force it might have in other areas, where a utilitarian argument might involve doing harm to innocent persons. The prevention-oriented general practitioner is not faced with a moral requirement to dismember a mildly injured patient for spare parts, as a utilitarian surgeon might be. The interventions which the prevention-oriented doctor will be advocating are intended to benefit the individual patient.

However, the problem continually arises in a weaker form, when patients do not want to do what is required to maximize their own individual health, let alone the health indicators of the community. As Hart (1988) points out, patients in a health promotion model are "colleagues in a jointly designed and performed production, in which they will nearly always have to do most of the work." This is fine when both doctor and patient want to produce the same result; we know, however, that often patients do not wish to know about maximizing their long-term health, as Hart perceives it, preferring instead the short-term satisfaction of a packet of cigarettes, for example. The rationalist model of respect for autonomy can do little more than shrug its shoulders at this point.

Furthermore, the notion is not helpful in deciding what is legitimate in this area. There is a spectrum (some would say a slippery slope) between the doctor who says, "If you smoke, you will probably die of lung cancer or heart disease; if you stop you probably won't. Those are the choices; make your own decision," and the one who tears up the patient's cigarettes and refuses to see them again unless they stop. There are levels of persuasion and cajoling, of encouragement and warning, which are not well construed on the basis of a dichotomy between paternalism and respect for rationalist autonomy.

We have also seen that it is difficult to deal with interpretative theories within this concept of autonomy. This is because these theories reject the rationalism and dualism of the Enlightenment model of autonomy. Doctors and patients in Balint (1957), Brody (1990) and Heath (1995) move in a deeper, more shadowy world of unconscious needs, desires and fears which affect both the mind and the body.

Apart from these difficulties, rationalist autonomy is a purely negative notion. Pellegrino and Thomasma (1988) have pointed out that illness is often associated with impaired autonomy, and that one goal of treatment can be to restore autonomy to the patient. However, even this notion limits us to a static view of personhood which is inadequate, the aim being merely to restore the person to his or her original state. No potential exists here for growth or development.

We need to think of autonomy not as a possession to be treasured but as an ability to be fostered and developed: to make choices and plan one's future, and to do so from as wide a range of options as is reasonable; to face crises and to deal with a variety of situations. In Kelly's terminology, it includes both the extensiveness and the flexibility of construct systems. It needs to be extended to the emotions and the will as well as to the reason, to be available to the body as well as to the mind.

This approach uses a positive rather than a negative concept. In this sense, respecting the patient's autonomy does not mean restricting one's actions to avoid infringing autonomy, but planning one's actions so as to enhance it. Respecting autonomy implies being reflexive, in the traditional moral sense of "do as you would be done by". This includes being patient-centred, and listening to patients and their concerns. Conversely, it implies avoiding emphasizing one's own agenda, even when this is directed to beneficent ends, such as health promotion and biomechanical health.

Most controversially, respect for autonomy may involve short-term paternalism in order to enhance autonomy in the longer term. An obvious example of this is pumping the stomach of someone who has attempted suicide. This action, in which there is no room for free and informed consent, enhances autonomy in the long term by giving the patient the chance to reconsider what experience shows is often a hasty decision. Even when people are less rationally compromised by emotion, sensible advice firmly given can be necessary if their long-term options are not to be restricted. There can be few people who when unwisely fighting off illness have not had to be told to go to bed and stay there. Clearly, this can merge into inappropriate paternalism, and the boundaries need to

be drawn more clearly. Respect for autonomy does not, however, exclude biomechanical interventions, many of which can be seen as enhancing physical autonomy, although some may diminish it.

## The narrative concept of selfhood

A problem with the biomechanical and most humanist concepts of selfhood is that they lack a temporal dimension; they are static, whereas people exist, change and develop over time. This static view leads people to talk of *returning* the patient to health (Pellagrino and Thomasma, 1988). This must, of course, be nonsense. One can no more return a patient to health than put the clock back to last Tuesday night. What one can do is help patients to move forward to a future which holds more rather than less health than might otherwise be the case.

We often think of people as existing at one moment in time, whereas each of us has a past and, to an unpredictable degree, a future. Considerable interest has been shown recently in the idea of narrative as a solution to the problems raised by philosophical models which adopt a "time-slice" approach. Macintyre (1985; p.203) points out that we can only understand a human life within "a concept of a self whose unity resides in a narrative which links birth to life to death as narrative beginning to middle to end. Brady (1987) and Heath (1995) have explored the idea that the interpretative function of the doctor is closely linked to the need we all have to understand our "stories of sickness" (Brady, 1987). The doctor's role may not even be that of interpreter, but merely that of witness (Heath, 1995). The need to organize our life, including that important aspect of our lives which is our sickness, into narratives is part of our relentless "search for meaning" (Abercrombie, 1960). Hunter (1991) points out that this is not only an important function of medicine, it is its ceaseless activity - in case reports and case discussions as well as in consultations with patients.

It seems clear that the idea of narrative is important to general practice. The patient comes to the doctor for help in incorporating an illness within the narrative of his life. This can be done both by resolving it as a subplot, and by integrating it into the larger plot of life. Neither of these is better than the other, although the options available may vary.

The idea of narrative has considerable potential. It gives us a starting point for a more adequate concept of the human person; a basis for a fuller notion of autonomy extending and developing over time; and a place from which to make sense of illness in human life. It offers an approach to reflexivity; doctors have a narrative as well as patients, and practice is an important arena in which doctors make sense of their own narratives. The doctor-patient relationship is one subplot within the patient's overall narrative. The doctor may simply play a bit part in the patient's life or may be a major character. The cases which are important in the doctor's own narrative are those in which a major role is played, which is why both for Balint and for the biomechanic the difficult case looms so large.

Both the biomechanical model and many versions of the humanist model are individualist, seeing persons as isolated phenomena. In fact, although value-laden concepts of family are unhelpful (Marinker, 1976), everyone exists in a social and cultural context, and the person cannot be abstracted from it. Again, the narrative concept may be useful in helping us to understand that aspect of our personhood which exists in our relationships with others.

Many issues still require further exploration. What is a good narrative? Can we borrow concepts from literature? Is the good narrative, for life as for art, one in which characters develop in complexity to become convincing real people, not cardboard figures? One in which the narrative has an organic unity, without loose ends and unresolved tensions? Literary narrative may furnish useful analogies, but life and art are different. In life, the creator of the narrative is also the principal protagonist, not an external figure. The narrative concept of selfhood is autobiography. Here again, Kelly (1955) may be helpful in giving us a framework, for he is interested in construct systems not only as static descriptions at a point in time, but as a way of measuring change, which he sees as vital.

There are inherent limitations to the concept of narrative. A narrative cannot be fully evaluated until it is over. Life has to be lived forward, but can only be understood backwards. This, not that one is better off dead than alive, may be what Solon (Herodotus, *Histories*, I, 32) was suggesting in his famous statement "Call no man happy until he is dead." Thus it is difficult to use narrative quality as a guide to action. Despite these problems, narrative does offer potential for improvement on static models of selfhood.

## Conclusion

In this discussion, we have considered some of the differences between the two models of selfhood, and the limitations in the range of convenience of each. We have also explored and clarified the points of conflict, and identified opportunities to develop them into fuller models with a wider range of convenience. As is so often the case, this has raised more questions than it

has answered. In some respects, the models act as counterweights, each redressing the inadequacies of the other. The reality is that human persons are both objects and subjects. The transformation from one to the other can be both sudden and unexpected. I once stepped off a kerb, and in a few seconds was transformed by gravity and an awkward fall from an autonomous, if not very surefooted, independent human being into an object with a forearm the shape of a dinner fork - an experience with a considerable impact on my own narrative.

It has been suggested that the two models merely represent different levels of explanation, related to each other as physics is to chemistry, and chemistry to biology. It may be that the biomechanical model is a necessary foundation for the humanist model. However, since these models are used to plan interventions which affect people and not merely to predict aspects of the physical world over which we have no control, our choice between the two models is not merely a practical matter of deciding which model best explains certain aspects of our empirical experience. It is a matter of values.

We have not explored the difference between the externalization of an experience or a phenomenon as an illness and its integration into our life narrative, one of the differences listed in Table 1. Our approach to this issue depends upon our values, and determines our understanding of the doctor-patient relationship. These are the questions which we must now address.

# Chapter 4

# The meaning of illness

In the biomechanical and anticipatory care theories, the prime purpose of medicine is the extension of life; the secondary purpose is the avoidance of pain and anything which may inhibit pleasure. These values are those of the utilitarians. In contrast, the aim in the interpretative theory is to understand illness and to integrate it as far as possible into the life narrative of the patient, where necessary modifying the patient's life plan to accommodate it. If we are to reconcile these approaches, we must consider in more depth the nature and meaning of illness.

We need to be clear about the difference between illness and disease. We will see that the boundary between one disease and another, between a particular disease and health, and between illness and health is fuzzy. Our decision on where to place a particular case will be affected by our expectations of the individual and our fundamental values. We need to understand the effects of externalizing illness, both on the way the illness is experienced and on its validity as an excusing factor.

## Illness and disease

Illness and disease are often confused, sometimes used as synonyms and sometimes distinguished from each other. Moreover, in trying to remove the confusion, different writers define the terms clearly and explicitly, but differently. This means that in practice the terms have to be defined afresh by each writer if we are to avoid confusion.

An important distinction occurs between a particular sort of negatively evaluated state and diagnostic categories used as empirical classifications of conditions according to our knowledge of symptom patterns and pathophysiology (Toon, 1981). I shall refer to the first as illness and the latter as disease. Most disease diagnostic categories are negatively evaluated as states which one would like to change, but their main function is as intervening variables between symptoms and treatments, defining a state of affairs that should be changed by external means (evaluative) and linking it to a treatment that will do so (empirical). One disease is contrasted with another, as well as with health. There are also non-illness diagnostic categories, which are defined in similar terms to diseases but not negatively evaluated, for example Gilbert's syndrome and Meckel's diverticulum. We lack a general term for these, although 'anomalies' is used for many of them.
Because diagnosing diseases demands most of a doctor's attention, we often take for granted the more fundamental issue of whether the patient is ill. Fulford (1989) points out that deciding someone is ill must logically precede diagnosing a particular disease. Attempts to find a purely biological definition of illness (Boorse,1975; Campbell et al., 1979) have proved defective. Fulford argues that the decision that someone is ill is based on an experience of 'action failure': the person is unable to perform an action normally within his or her competence. It is entirely an evaluative, not an empirical, judgement.

## Separation of illness from the person

Illnesses are external to and separate from the sufferer, not part of the person. Defining mental or physical phenomena, subjective experiences or observable features, as symptoms and signs of an illness and not as personal characteristics separates them from the individual. This externalization devalues them. They become merely pointers to a diagnosis, epiphenomena of an affliction.

However, we should not see this externalization as entirely negative. It helps us deal with the intolerable: 'humankind cannot bear very much reality' (Eliot, 1936). Periods of illness are interludes in life with special rules - similar, in a way, to holidays. Externalization of an illness which would otherwise be overwhelming lets us take advantage of external ways of altering them, and may allow longer-term gains in autonomy. Separation of phenomena as illnesses frees us from responsibility for their consequences. This oils the wheels of society, supporting the quality of mercy without which civilized life would be impossible. Acute appendicitis, influenza, schizophrenia, broken legs and polymyalgia rheumatica, for example, are diseases for which this approach can be sensibly applied. However, the cost of externalizing illness is loss of control.

## Limits to externalization

A Colles' fracture is perhaps one of the most obvious illnesses to externalize, and was used as an example in *What is Good General Practice?* (Toon, 1994a). Yet it also illustrates the limitation of externalization. A sudden fall can transform one's life plan, at least for a few weeks. To imagine that such an experience can be separated from life and make no difference is clearly nonsense. To a greater or lesser extent, the person one

is and what one does for the rest of one's life are changed by such events.

## Illness as an excusing factor

Consider the following statements:

*The Queen has cancelled her engagements for the rest of the week, as she has a slight chill.*

*The accused pleaded not guilty, by reason of diminished responsibility.*

*Dear Doctor, the above patient has applied for a grant from the social fund to buy a new bed and a washing machine. Can you please confirm that these are medically necessary because the patient suffers from a bad back?*

*I have examined you today and advised you to refrain from work for two weeks with a diagnosis of nervous exhaustion.*

Although illness is by definition negative and undesirable, these examples illustrate that it has some compensating social benefits. These may be positive, like the new bed and washing machine, but more commonly they are negative - being let off something which would normally be expected of us, such as opening a school, going to work, or being imprisoned if we have committed a murder. Millions of decisions are made on the basis of illness as an excusing factor - 375 million days of absence from work each year in the UK alone (Coggon, 1988), not to mention the countless social engagements cancelled and chores escaped. Now contrast the above statements with these:

*The Queen has cancelled her engagements for the rest of the week, as she has a bad hangover.*

*The accused pleaded not guilty, by reason of having lost his temper.*

*Dear Doctor, the above patient has applied for a grant from the social fund to buy a new bed and a washing machine. Can you please confirm that these are necessary because the patient hates washing and likes to lie in bed all day?*

*I have examined you today and advised you to refrain from work for two weeks as you have been staying up late at parties and are too tired to go to work.*

The first set are acceptable excusing factors because the conditions are illnesses, whereas those in the second set are not. Fulford's action failure (1989) is different from personal failure. When I wake up and find I cannot raise my arm above my head, I construe it as action failure and decide I must be ill. Responsibility, and consequently guilt, are removed. This fulfils the important adaptive process of keeping what I have to do within tolerable bounds, but it also puts the problem outside my control. Externalized problems have external solutions: drugs, surgery, physiotherapy, treatments applied by others. We change from being autonomous agents to passive beings - patients.

## The dualism of illness

Illness, both physical and mental, is seen in the dualist, biomechanical model to be caused in the physical world, where determinism rules. This means that we are the victims of illness and are not responsible for it. In the mental world, by contrast, free will comes into play and we are responsible. Illnesses such as chills, mental illness, bad backs and exhaustion originate in the physical world and are outside our control, whilst personal characteristics like bad temper and laziness originate in voluntary mental actions of the will.

We saw in the last chapter that the relationship between mind and body, responsibility, volition, blame and guilt is more complex than this. Some illnesses are caused by the sufferer's acts. Lung cancer, alcoholic cirrhosis of the liver and self-poisonings are the most obvious examples. In other cases, for example skiing accidents, the risk of illness is related to voluntary actions and might have been foreseen. Highly infectious diseases, such as pneumococcal pneumonia, meningitis and chickenpox, and some accidents (walking down a street and being struck by a falling slate, for example), just seem to be bad luck. Yet we know that even here, preoccupation or carelessness often plays a part in the chain of events which cause illness. Some illnesses are congenital or the result of a hereditary predisposition - sickle cell anaemia or thyrotoxicosis, for example. Are we responsible for these? We do not choose to have them; but nor do we choose to have a short temper or a depressive tendency, yet these are also influenced by our genetic inheritance.

People commonly deny responsibility for their problems and define them as illness to avoid guilt or blame: 'It's my nerves, doctor.' This may be a useful way to avoid paralysing guilt. However, externalization leads to a search for an external cure - 'What can you give me for it?' - which can close doors to self-control and empowerment. As we saw in the last chapter there may be occasions when these constructs need to be disentangled.

Linked to this everyday use of illness as an excusing factor is its use in law. This is a special problem of

forensic jurisprudence; it differs from the issue that we are considering. The legal concepts of diminished responsibility and the consideration of illness as an excusing or mitigating factor in lesser cases are different in purpose from medical diagnostic categories of illness (Toon, 1982). It is not appropriate for us to explore further this complex issue, which has been much debated elsewhere (Hart, 1968).

## Fuzziness of the boundary

Diseases are defined in various ways. Some are based on pathology, others on pathophysiology or aetiology. Others are empirical descriptions of symptoms, symptom clusters or behavioural descriptions which experience has shown to be helpful in prognosis and in predicting the effect of treatment. It is therefore not surprising that diseases do not form a tidy pattern of descriptive categories.

Some disease categories are qualitatively different, both from health and from each other. Either one has a broken leg, or one doesn't. There is a clear difference between, say, a Colles' and a Smith's fracture. Empirical predictions vary from one diagnosis to another. It may not be diagnostically certain whether someone has a particular condition, and cases in the same disease category differ in severity, but a definite discontinuity exists between discrete disease categories.

Other disease categories are not so clear. Different diagnoses may lead to similar treatment plans and prognoses (a phenomenon encapsulated in the cynical definition of dermatology as the art of describing rashes in Greek and putting steroid cream on them). In rheumatology and psychiatry, symptom clusters with overlapping and unclear pathology (such as polymyalgia and temporal arteritis, schizophrenia and affective psychosis) merge into each other.

In other conditions, the distribution between those who fall into a diagnostic category and those who are healthy is continuous. An obvious example of such a condition is hypertension, because of the ongoing debate about where the boundary should be drawn, but there are many others. Diabetes and asthma are other physical examples, but this continuous distribution is found in mental illness also. Anxiety and depression merge imperceptibly into each other, varying between complete psychological breakdown and mental health.

Even the distinction between qualitative and quantitative is not always clear, and categorizations are made at all levels of measurement from nominal to ratio - sometimes on a complex combination of measures, as in the revised Jones criteria for the diagnosis of rheumatic fever (Weatherall et al., 1987; p13.279).

The evaluative decision of whether someone is ill also has a fuzzy edge. There is no rule as to whether a phenomenon should be externalized. Some illnesses, such as cancer, are almost always externalized (although Maitland [1990; p.206] chillingly suggests that even this is not invariably the case); others are always integrated. But there is a grey area in between. In such situations, the evaluative and empirical aspects of the decision are often confused. Who has not woken up slightly aching, with a muzzy head and a stuffed-up nose, uncertain whether the cause is a cold, a late night or an overheated bedroom?

Empirical and evaluative judgements are often both involved in deciding where to draw the line. What, empirically, are the benefits of reducing blood pressure by drugs at a diastolic pressure of 100 rather than 105? How much should we value the risk reduction to the individual against the costs to the community and the psychological effects of being labelled ill?

We can clarify our thinking by separating the initial evaluative decision of whether the person is to be considered ill from the subsequent decision of what disease the person has. To do this, we must take into account (and strive to disentangle) all the implications of that decision regarding responsibility, excuses, externalization and lack of control. Nevertheless, we cannot avoid making hard decisions.

## Values and expectations

If illness, as Fulford (1989) suggests, is defined by action failure, we must decide whether the action we cannot perform is one which we might reasonably expect to perform. This depends on our expectations of ourselves as individuals. For me, being unable to get out of bed is clearly an action failure of the illness type, but being unable to run a marathon is not. A athlete in training will not expect to suffer pain and stiffness in a knee after running a mile, whereas someone less fit might expect pain or loss of function after much less strain. An elderly person might attribute a similar set of symptoms to 'old age'. An identical pathology or disease process may underlie each experience, but personal expectations determine whether it is seen as an illness or not.

Our approach to illness also depends on our values. The identification of depression in general practice illustrates this well. Many studies have found that general practitioners often do not diagnose depression in patients who meet objective psychiatric criteria (Freeling et al.; 1985). This behaviour is usually

attributed to diagnostic failure. No doubt this is often so; *ars longa, vita brevis* (the art [of medicine] is long but life is short). This may apply particularly to mental illnesses, where there are fewer hard clinical signs and investigations to confirm a diagnosis, and where diagnostic categories often merge into one another. Moreover, doctors and patients may have a psychodynamic resistance to recognizing psychological problems, finding a somatic illness easier to handle.

There is, however, another factor. Whilst, increasingly, general practitioners have access to cognitive therapy, and some can use its basic techniques, drugs remain the main treatment for depression. Thus the doctor may diagnose 'a case for lofepramine' rather than a case of depression. If the doctor feels that drug treatment is not indicated, they may not identify the problem as one to be externalized as depression, even though formal psychiatric criteria are met.

Patients too do not always externalize depressive experiences. Many patients who meet formal diagnostic criteria do not complain of low mood or other features peculiar to depression, but present complaints such as headaches, back pain, or tiredness (Paykel and Priest, 1992); this can happen even when questioning reveals psychological symptoms of depression or a recent life crisis, such as bereavement or the break-up of a relationship. Furthermore, even when the diagnosis of depression is proposed and accepted, patients frequently decline drug treatment.

There may be empirical reasons for this. Patients cannot be expected to analyse their experience as doctors do. Many patients find the side effects of antidepressants worse than the disease. As a result of a successful campaign against tranquilliser abuse, many people fear the addictive potential of any psychotropic drug.

Often, however, for patients as for doctors, this is not an empirical problem of failure to diagnose the disease, but an evaluative decision not to externalize an illness. Diagnostic criteria for depression have been defined by psychiatrists, who mostly see patients with severe depression that is very different from most human experience. General practitioners see a broader spectrum of depression, which shades imperceptibly into normal human sadness. We all experience loss: bereavements, broken relationships, unfulfilled ambitions, disappointments. Often this leads to broken sleep, low mood, feelings of self doubt and lack of interest in other aspects of life. We can conceptualize such experience in three ways:

- As an unpleasant, tedious but unavoidable part of life, like visiting the dentist or preparing information for the tax authorities.
- As a painful but useful part of life, from which we can learn and grow: a challenge to 'go through the vale of misery, using it for a well' (The Bible; Psalm 84: 6).
- As reactive depression. In this analysis, the experiences are still seen as unpleasant and tedious but are merely symptoms of an illness, and have no meaning in themselves. We seek a cure in drugs to return us to the state we enjoyed prior to this illness.

The most important difference between these views is the degree to which the experience is internalized (in the first case from a pessimistic, and in the second from an optimistic viewpoint) or externalized, with all that implies. Choosing when an experience should be externalized and when it should be integrated into our life narrative depends on whether we see the experience as the type of action failure which characterizes illness. There are various actions which we may see as having failed in depression, for example having pleasure, coping, being successful, sleeping properly.

What we see as action failure depends on our view of the nature and purpose of life. Although this affects the decision to externalize both somatic and psychological experience, an illness diagnosis is more likely to be rejected for psychological than physical symptoms. In a society conditioned by dualism from Plato (e.g. *Phaedrus*) onwards, externalization of bodily experience is more acceptable than rejection of the mental. 'I think' is more central to our self-image than 'I move' or 'I digest'. Therefore, to cut off part of our bodily experience metaphorically, or even literally through surgery, is comparatively easy; to cut off part of our mind is much harder.

Normally, we muddle through, externalizing or integrating on intuitive, pragmatic or arbitrary grounds. Yet where we place this boundary has important practical implications. Many areas of medical treatment are controversial because they lie on this boundary. Are menopausal flushes part of the natural history of the changes which make up our life story, or a hormone deficiency state requiring substitution therapy? Is an unattractive chin something we are born with and must accept, are sagging face muscles part of growing older, or should we see these physical defects as illnesses which merit definition as diseases and appropriate surgical correction? Medical treatment of infertility, the surgical removal of tattoos, and the use of growth hormone for short stature involve similar evaluative judgements.

The human genome project will shortly extend this problem into new areas. Most people see the eradication of sickle cell disease and cystic fibrosis as

desirable conquests of disease, but the eradication of bad temper, red hair or black skin would be viewed as dangerous manipulations in eugenics. How do we draw the line? We have to distinguish between congenital illnesses which should be modified by genetic engineering, and congenital aspects of the person which should not be modified. These decisions are essentially evaluative.

We have an Advisory Committee for Borderline Substances to distinguish between drugs and non-drugs. Its proceedings are confidential, so I have no idea what criteria it uses to make its distinctions. Perhaps we need a similar committee for borderline illnesses, although one would hope that its deliberations and criteria would be made public. Controversies over treatment in such areas cannot be resolved unless we see them in the context of the personal characteristics and life narratives of the individuals concerned - and in the light of a particular view of the nature and purpose of life. It is this last which will form the subject of the next chapter.

# Chapter 5

# A question of values

The last two chapters have explored some of the differences between the three theories of medical practice. These differences are mainly evaluative. We must therefore examine our values if we are to see how the theories might fit together into a unified concept of good medical practice.

## Hedonic and teleological value systems

Philosophers have discussed the nature of the good life from the time of the Greeks. Conclusions vary widely, but as suggested previously they can be broadly divided into two categories. The hedonic view is that pleasure is the good to be maximized, while pain is bad and to be avoided. This view is associated with the utilitarians, and it is true that Jeremy Bentham (Honderich, 1995; p.733) suggested that all sources of pleasure were of equal value ("pushpin as good as poetry"), but the view dates back to the Greeks. The "Let us eat, drink and be merry, for tomorrow we die" philosophy of hedonism (referred to in the Bible; 1 Corinthians 15: 32) was popular two thousand years ago (Honderich, 1995; p.337). Aristotle attributed it to Eudoxus (*Ethics*, Book 10) and despised it as bovine, suitable only for the vulgar.

To him, as for many other philosophers, the good life had a purpose, a telos, beyond mere enjoyment. For Aristotle, this purpose was the cultivation of virtue. For Ignatius of Loyola (Corbishley, 1973), it was to save one's soul by praising, revering and serving God. Many others have sought a meaning in life beyond the pleasures of the moment, turning to contemplation of the good, or working for some good cause such as the poor, the patria or the perfection of the soul. To those who seek them, these goods are more important than pleasure. In their pursuit, suffering might be incurred, and pleasure - even life itself - sacrificed: *Dulce et decorum est pro patria mori* (Horace, Odes III, ii, 13).

Generally, human beings do seek pleasure and avoid pain. This seems to be an essential part of the good for us, but it is not the whole story. We also seek to understand our lives. Psychologists have been unable to explain human and even animal motivation without some notion of curiosity or need for understanding. For Kelly (1955), human beings are scientists, forever struggling to make sense of experience and to find better ways of predicting how the world works. Abercrombie (1960) reached the same conclusion from a study of perception and decision making, pointing out that this search for meaning is not some luxurious fad or intellectual game, restricted to middle-class Viennese neurotics or French intellectuals, but a basic biological necessity.

## A value judgement

To say that the search for meaning is common amongst human beings is an empirical statement. It was made clear in Chapter 1 that this work would make assumptions with which some readers may disagree. One of these is to go beyond this empirical statement to an evaluative judgement. An axiom of the rest of this work is that Aristotle is right: that it is preferable to see life as having a shape and purpose, as embodying a search for meaning and a pursuit of some goal, than to see it as a formless series of pleasures and pains. Those who believe that there is no more to life than the maximizing of pleasure and the minimizing of pain may therefore disagree with the conclusions which follow.

This is not to imply that we must agree over the purpose or meaning of life. For some, this purpose may lie in another person or people, for others in God or holiness, or in a cause or abstract ideal. For many, it is a combination of all of these. Part of each individual's search for meaning is to determine his or her own *telos*. Nor am I suggesting that pleasure is not preferable to pain, or that a long life is not better than a short one, although some teleological views hold this to be so (Corbishley, 1973); I am merely proposing that seeking pleasure and avoiding pain are not the highest goods. Just as the humanist model of personhood offers a more extensive construct system with a wider range of convenience than the machine model, so the teleological position offers a view of human life which is empirically more satisfactory as an explanation of human behaviour and which, evaluatively, offers the chance to aspire to higher goods. Having made this value judgement clear, we can return to the examination of our theories of medical practice and their values. What is the role of medical practice in human life?

## Value systems and theories of medical practice

Hedonic values appear to be implicit in the biomechanical and anticipatory care theories, where the doctor's role is to repair or maintain the patient's body so that life is as long and as pain-free as possible.

The interpretative theory sees the doctor's role as helping the patient to make sense of illness, integrating it into a life narrative as part of the teleological search for meaning. There appears to be a clear dichotomy, but Doyal and Gogh's theory of human need (1991) may help to resolve this.

## A theory of human need

Doyal and Gogh's political philosophy is concerned with developing a theory, applicable worldwide, of the just allocation of resources. They attempt to do this by seeking to define minimal human needs (as opposed to wants) for a good life in any society. They point out that whatever our *telos* is, its fulfilment depends on social participation: "Whatever our private and public goals, they must always be achieved on the basis of successful interaction, past, present or future with others . . . Unless individuals are capable of participating in some form of life without arbitrary and serious limitations being placed on what they attempt to accomplish, their potential for private and public success will remain unfulfilled - whatever the details of their actual choices." As Aristotle said, "human beings are political animals" (*Politics*, I, 2).

Doyal and Gogh argue that the minimum requirements for this participation are survival with a basic degree of physical health and personal autonomy, since "these are the prerequisites for any individual action in any culture . . . which must be satisfied to some degree before actors can effectively participate in their form of life to achieve any other valued goals." They therefore conclude that these are the two basic human needs, and that justice demands that we make them our priorities. They go on to define a number of intermediate needs, such as adequate housing and nutrition, which must be provided if these two basic needs are to be met.

Because they are concerned with the needs which basic human rights and distributive justice demand be met if possible, they focus on the minimal level of health and autonomy needed to participate in society: "The basic physical health needs of individuals have been met if they do not suffer in a sustained and serious way from one or more particular diseases." They argue convincingly that the biomechanical model provides the best "cross-cultural foundation on which to compare, understand and sometimes improve the physical health of people in differing social contexts". Personal autonomy is "the ability to make informed choices about what should be done and how to go about doing it".

Although there are problems of definition at the boundary, these bottom-line definitions will prove useful when we come to discuss medical priorities in our consideration of justice (Chapter 8). Although these are the minimal requirements, both autonomy and health can go beyond the minimum. We do not have to be as over-ambitious as the World Health Organization, which defines health as "a complete state of physical, psychological and social well-being", to recognize that there are degrees of physical well-being above the absence of serious disease. Similarly, we saw in Chapter 3 how a dynamic concept of autonomy as something which can be developed and cultivated is possible. In both cases, a ceiling is set by factors inherent in the world, such as human nature, our mutual interdepedency, the incompatibility of certain choices, the certainty of death and incurable disease, and levels of resources.

## The role of medicine

Doyal and Gogh's theory provides an alternative construct to the hedonic-teleological dichotomy to help us understand the relationship between the biomechanical and the interpretative theories of medicine. Medicine has a role to play in raising both physical health and autonomy to Doyal and Gogh's basic level, and beyond that level where resources permit.

Aristotle (*Ethics*, Book I) says that "the good of medicine is health", and medicine is usually thought to be solely concerned with the first of Doyal and Gogh's two needs: physical survival and physical health, biomechanically conceived. Although the emphasis has recently been on individual intervention and the health service in meeting these needs (Secretary of State for Health, 1991), the task is not the responsibility of medicine alone. Doyal and Gogh point out that other intermediate needs, particularly food and water, housing and a safe physical and work environment, are also crucial to health. There is evidence that even in developed societies access to these goods is more important to health than access to medical care (Black et al., 1982). Nevertheless, biomedicine does have a role in sustaining that "bottom line" of physical survival by curative and preventive actions. Doyal and Gogh include health care amongst the intermediate needs.

But this is only half the truth. After making a diagnosis, the doctor can offer not only treatment but also a prognosis. In contemporary medicine, the emphasis on the power of technology to alter the course and outcome of disease has led to the prognostic role being neglected. But patients seek medical attention to be told what their illness is, as well as (and sometimes instead of) to be made better. Knowing that a fractured rib will hurt for eight weeks does not alter the pain or make it any less limiting on one's life, yet people wish to know

such things. Prognosis is part of our effort to make sense of an illness. For this reason, the giving of prognostic information is part of the other aspect of medicine, its interpretative function. This contributes to personal autonomy.

Prognosis is not the only medical activity which is interpretative. Diagnosis, the explanation of the nature of an illness in terms of some coherent theory of disease (whether rational or not), is welcomed by patients for the understanding it brings as well as for the treatment it offers. What doctor has not seen patients leave a consultation content that their affliction had been given a name, even if no treatment had been offered? Sometimes, merely returning patients' complaints to them more clearly defined in a dead language brings comfort. Belief in the power of naming to give us control is ancient. Both clinical experience and anthropological research reveal the universal struggle to find explanations of illness within the body or in the environment (Fuller and Toon, 1988). If biomechanical science cannot furnish an explanation, patients turn to alternative medicine or invent one for themselves.

Nor is prognosis merely the mechanical attachment of an outcome to a pathophysiological state, as in the simple statements "Chicken pox spots take a week to dry up," "You feel tired for six months after a hysterectomy." The analysis of an illness, its aetiology and its prognosis is often specific to an individual. The process of defining this with and for patients enables them to learn more about their own selves, their strengths and weaknesses. It enables the patient to "integrate it into his life narrative" (Brady, 1987; Macintyre, 1985), to use it as part of the story which is his or her life. If a necessary part of human flourishing is to construct as rich a life narrative as possible, with as few avoidable limitations on one's choices as there can be, then medicine has a crucial role in helping us to deal autonomously with ill health. This is a particular role for primary care. Heath (1995) considers that managing the boundaries between health and illness, and between illness and disease (Figure 4),

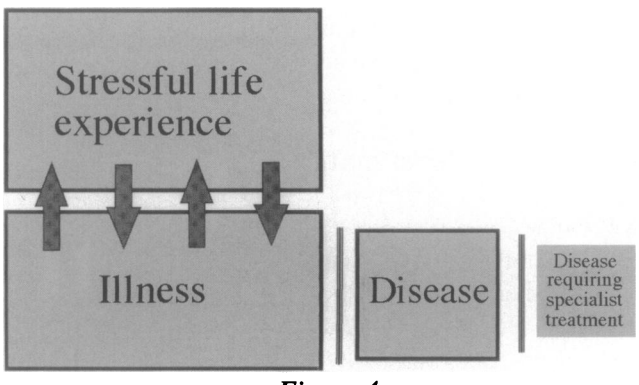


*Figure 4*

is as important a role of general practice as the morewidely discussed "gatekeeper role" for managing the interface between primary and secondary care. All these aspects of the interpretative function enhance autonomy.

## Three related but separate constructs

We thus have three pairs of concepts. Medicine has two aspects: the biomechanical and the interpretative. Hedonic views of life are contrasted with hermeneutic views. Basic human needs can be reduced to health and autonomy. In Kelly's (1955) terminology, we can use these three bipolar constructs to construe medical actions. It is tempting to see the anchors at each end of these constructs as mutually exclusive alternatives and to link them closely together, as in Table 4.

***Table 4*** Constructs used to construe medical actions.

| | |
|---|---|
| Biomechanical | Interpretative |
| Hedonic | Teleological |
| Health | Autonomy |

There are two flaws with this approach. First, the concepts which anchor the constructs are not mutually exclusive. Secondly, the three constructs are not equivalent but independent.

## Biomechanical and interpretative functions

Some medical actions may be solely biomechanical, others solely interpretative, but in many cases the consultation and subsequent actions of doctor and patient include elements of both. Where no treatment is available, the doctor can do nothing except help the patient to bear what has to be borne. At the other extreme are cases where there is little meaning to be extracted from the experience, and where removing the obstacle is the sensible course. The barrier to social participation posed by deafness due to the blockage of the external auditory canal with wax is best removed by syringing, rather than by trying to understand its ontological significance.

More often, the interpretative and biomechanical functions can be fulfilled simultaneously or in parallel. Understanding the complex mixture of physical and psychological stresses which can give rise to back pain, and accepting the role of exercise, stress management and a good lifting technique in avoiding such pain, does not preclude the use of analgesia and embrocation.

We need to pay more attention to measuring the interpretative function and to performing it well. Current outcome measures tend to neglect it. There is no reason why the interpretative function should not be researched with as much scientific rigour as treatment effects, as Bruster et al. (1994) and Howie et al. (1997) have demonstrated. Some of the hostility which audit and performance indicators generate may arise from an unformulated awareness that this important aspect is being ignored. At a time of increasing emphasis on audit, quality control and cost-effectiveness, if we do not measure our interpretative activity then it will be squeezed out - to the detriment of our profession and our patients.

## Hedonic and teleological viewpoints

The search for meaning and the quest for pleasure are not usually mutually exclusive, except perhaps in some puritanical belief systems. Even for Puritans, the ultimate goal was the eternal pleasure of the beatific vision (unless one was unfortunate enough to be predestined to eternal damnation), and the misery of life was a necessary means to that end. These constructs are not opposite poles but continuous scales along which actions can be placed according to their nature and their consequences.

However, there are occasions when a choice has to be made. Should patients go on battling with the strains which depress them, thus developing the virtues of fortitude, justice and magnanimity at the cost of considerable suffering to themselves and those round them? Or should they give in and take antidepressants so that in a week or two they can start enjoying life again? In such cases, the patient will have to decide with the doctor. Their decision will depend, in part, on whether they are hedonists or teleologists. This apparently esoteric distinction is therefore of practical importance.

## Health and autonomy

Health and autonomy are similarly intertwined. Impaired biomechanical health usually decreases the potential for autonomous action. It is important to be clear whether this is a direct result of the illness (as when I have a bad cold and want an ice cream, but feel too weak to go to the corner shop to buy it) or whether it is a consequence of society's attitude to the illness. Those whose health is impaired often have to struggle to maintain even a basic level of autonomy; their needs may be neglected and, especially if they are elderly or physically handicapped, they may have to endure the maternalism of much medical care ("does he take sugar?"). The direct effect of illness on autonomy is inevitable, but indirect effects can be removed by measures such as education in attitudes and providing disabled access.

## Independence of the three constructs

In Chapter 3, we saw some of the problems which can arise from treating constructs about human persons as identical. A similar argument applies to the three constructs discussed here. Where we decide to place an action on one construct scale does not determine its place on the others. They are correlated but not identical.

Biomechanical interventions predominantly promote health, and interpretative ones mainly enhance autonomy; but biomechanical interventions can enhance autonomy as well as health. Someone who is severely depressed and unable to function can increase their capacity to make choices and participate in society by accepting drug treatment. Operations frequently diminish short-term autonomy for the sake of long-term gain, not only in health but in the range of choices which can be made. Explanation in biomechanical terms can frequently enhance autonomy by deepening the individual's understanding of himself and of the world.

Similarly, interpretative interventions can enhance health. This is part of the meaning of Balint's concept of the "drug doctor". Both the Balint literature and that of classical psychoanalysis are full of cases where physical symptoms causing pain or inhibiting pleasure have been removed by interpretation (Balint, 1957; Stafford Clarke, 1965).

Moreover, biomechanical intervention does not promote only pleasure, nor does interpretative intervention advance only teleological goals. Fulford (1989) reminds us that, ultimately, all suffering is mental, even if the cause is physical; and mental suffering can be removed or alleviated by knowledge and understanding. This applies not only to the "worried well", but also to those many patients with physical illnesses who find even a dismal prognosis easier to deal with than the fears of uncertainty. Conversely, biomechanical treatment may make an important contribution to some people's life goals. The treatment of infertility is one obvious such example.

## What matters more?

In *What is Good General Practice?*, the biomechanical and the interpretative approaches were distinguished as separate theories of good general practice. It is now clear that they are better seen as separate aspects of medical practice, both of which are necessary for good practice. Defining the boundary is difficult, and it must

be explored afresh each time a doctor and patient have to decide what balance is right in a particular situation. The above analysis only begins to sketch the framework for reconciling the biomechanical and the interpretative aspects of medical practice, but it is one in which decisions can be made clearly and the balance struck openly, rather than being buried in the depths of "clinical judgement".

On the basis of the evaluative judgement made at the start of this chapter in favour of the teleological view of life, we can define our priorities. The correlation between our three constructs suggests that autonomy, conceived dynamically, is usually the more important of the two basic needs. Physical health is a good to be enjoyed in itself, but more importantly it is a means to the enhancement of personal choice and development. Enhancement of dynamic autonomy is the more fundamental purpose of medical practice. In some cases, it is best achieved by externalizing illness using the biomechanical model, whilst in others this approach is impossible, or more is gained by integrating the experience into the life narrative.

This judgement also attaches greater importance to the interpretative aspect of medicine than to the biomechanical. To the teleologist, illness is not merely an irritating interruption to getting on and enjoying oneself, but is an important part of life itself. The interpretative function is necessary to a teleologist in a way that it is not to a hedonist. The principal purpose of medicine is to enable patients to enhance their autonomy by integrating their illnesses into their life narratives.

Integrating illness in this way is not the same as internalizing the experience as a non-illness. Sometimes, it is appropriate to externalize the problem. Where we can do this with little cost, there seems no reason not to do so. There is no need to make a drama out of a crisis. In such instances, the biomechanical theory, with its dualism, externalization of illness and assumptions, is an essential tool. However, even with simple illnesses that can be externalized, there is an interpretative role to play. Trivial illness is often presented not for symptom relief but in order to understand it: "I just wanted to make sure it wasn't anything serious, doctor." In many instances, the importance of this role is much greater, and on occasions a choice must be made between promoting autonomy and promoting health.

## Limits to medicine

Medical practice has been strongly criticized for its tendency to "medicalize" problems. We saw in Chapter 4 how sometimes this happens because we want to classify conditions as illnesses in order to benefit from the resulting freedom from responsibility and guilt. Sometimes, medicalization is a result of externalizing a condition as an illness when it might better be internalized as part of the person. Emphasizing the interpretative function and valuing autonomy and teleological goals over health and pleasure seems to exacerbate the risk of incorporating everything within the remit of medicine. How can we set limits to the role of medicine?

We cannot rely on the fact that medicine should be concerned with health, for the World Health Organization has shown how infinitely elastic this concept is. The answer I suggest lies in the "Oslerian" biomechanical theory (Hart, 1988). The doctor's role is to exercise both the biomechanical and the interpretative aspects of medical practice, but within certain limits. These are defined both by what the patient brings to the consultation, and by the scope of the biomechanical theory. The doctor's main role is to respond to the problems presented by "those who are or who believe themselves to be ill" (Spence, 1960; GMSC, 1996). The biomechanical theory defines the remit of medical activity, whilst the purpose of the activity should be construed within the broader, richer scope of the interpretative theory. If the problem is brought by the patient, and it falls within the scope of the biomechanical theory, then it is clearly appropriate for the doctor to deal with it. If only one of these criteria applies, then the doctor may have a role to play, but careful thought is needed to define what it should be. Of course, the edges between these categories are not sharp (Kosko, 1993).

Defining health is difficult, but medicine is fundamentally concerned with it. Health does not have such a fundamental role in relation to personal autonomy. Here, the central role lies with education, and with the political processes required to ensure minimal levels of civil liberty. Nevertheless, medicine does have a small but vital role in dealing with the threats to autonomy posed by illness and mortality.

## Linking biomechanical and anticipatory care approaches

Although far from complete, the framework above gives some clues as to how we might bring together the biomechanical and interpretative aspects of medicine. We can now start to consider how anticipatory care might fit into our model.

The most striking way in which anticipatory care differs from the other two models is in its population basis. The traditional approach of both biomechanical and interpretative medicine is to focus on the

individual patient with a problem. Anticipatory care is seen as encouraging the doctor to focus on the health indices of the group of patients for whom she cares. This utilitarian approach aims to maximize the good for all those involved. To the utilitarian, there is no place for particularity. Perhaps the clearest modern example of utilitarian thought is found in the writings of Peter Singer (1979). He argues that our duty is to maximize the good of the whole of humanity. There is no place for favouritism towards those we happen to know, or those linked to us by chance factors such as blood relationship or friendship. If we decide that the most effective way of relieving suffering is to donate to Oxfam, then we should express our altruism by donating the maximum amount compatible with sustaining our health.

This is unreal. It is part of human nature to show concern for those close to us, and to respond to the suffering that we see. To expect people not to do so for the sake of some abstract benefit to those they do not know is not psychologically realistic. Even to think in this way indicates the irrationality of excessive rationalism. If we wish to encourage an altruism that reaches beyond those close to us (towards whom it is traditionally, and some think biologically [Dawkins, 1976], strongest), we must find ways to extend our emotional responses so that "*alle Menschen werdern Brüder, wo dein sanfter Flügel weilt*" (All people will become brothers, where your holy spirit dwells) (Schiller, *Ode to Joy* in ***Beethoven's Choral Symphony***), rather than try to replace altruism with a mathematical formula.

Another example of the utilitarian approach is the Quality-Adjusted Life Years (QALY) system. Designed to enable a rational choice between health care expenditure on different activities, it is a way of attempting to quantify the benefits from treatments by measuring them in "quality-adjusted life years" (QALYs); this refers to the number of extra years of life which result from the procedure, adjusted to take account of the "quality" of those years measured (using the same method for all individuals) by the degree of disability and suffering endured. The treatment which provides best "value for money" is that which yields the most QALYs for a given expenditure. In a strictly utilitarian system, no one can be entitled to a minimum level of benefit.

QALYs demonstrate other difficulties of utilitarianism. According to the QUALY system, if an operation which gives one person an extra 15 years of life costs the same as 10 operations which give 10 people an extra year each, then we should spend the money on the expensive operation for one person. What each person has contributed, and the health care or other benefits each has received, can play no part in the decision.

Indeed, the logic of utilitarianism demands that, if necessary, individuals should suffer for the common good. In a traditional philosophical example, five people are in hospital on life-support systems after a car crash - two with renal failure, one with heart failure, one with liver failure and one with minor injuries. Utilitarianism suggests that, were transplant technology sufficiently reliable to ensure success, the right thing to do would be to kill the person with the minor injuries and distribute his 'spare parts' amongst the others. This treatment of people as means rather than ends has been widely condemned. Perhaps the century's most powerful evidence against such behaviour lies not in the works of philosophers, but in the results of systems which have seriously attempted to put it into practice, most notably state communism.

QALYs inherently favour the young, who if cured have more years ahead of them. However, the system cannot take into account the 'fair innings' argument that those who have enjoyed an average life span should give way to those with their life before them. In the example above, no difference would be made if the person needing the expensive operation were 65 years old and the other 10 were children. Although we do spend large, some would say excessive, amounts on dramatic cases with identifiable illness (as the furore over not doing so in the case of Child B, denied payment for a last ditch attempt at a bone-marrow transplant by her health authority because it was thought futile (Entwistle, Watt, Bradbury & Pehl, 1996) illustrated) this basis for resource allocation seems unacceptable to many people.

The difficulties a population approach poses in clinical medicine can be seen in the payments that have been made to general practitioners in the UK since 1990 for reaching targets of population coverage for childhood immunization and cervical cytology. There are strong financial incentives to achieve these targets, but no rewards for merely coming close: 90% is success and 89% failure. With large sums of money at stake, even the most moral of doctors may find it hard not to put pressure on parents to have their child immunized, or on women to have smears. Alternatively, doctors may alter the denominator by removing recalcitrant patients from their list. Examples of this have been well publicized and have caused great concern. Such policies conflict with fundamental respect for persons, and provide further examples of people being treated as means and not ends.

There may be empirical and epidemiological reasons why, to be effective, preventive activity should be

directed at populations as a whole; but a serious tension exists between the population approach and the Oslerian tradition of service to the individual patient. Utilitarianism sits ill with the values of autonomy before health, meaning before pleasure, and the interpretative function before the biomechanical.

It does not follow, however, that we must abandon the anticipatory care agenda. The doctor need not put the population before the person in order to act as an advocate of health with and for patients (Toon, 1987). Offering, as opposed to imposing, anticipatory care is a perfectly acceptable, indeed essential, part of the good clinical care of individuals. There are neither moral nor practical objections to such practice.

Part of the problem has been a tendency to see anticipatory care in terms of persuading patients to adopt healthier lifestyles, accept immunizations and attend for screening tests. This is part of a paternalist attitude similar to that underlying the notion of compliance in relation to drug treatment, whether preventive or curative. Marinker (1997) suggests that this approach is neither effective nor acceptable, and suggests that mutual understanding of patients' and doctors' health beliefs may be a preferable and more realistic goal. Similarly, the purpose of anticipatory care can be seen not in controlling patients to make them healthy, but in empowering them to make more informed choices and carry them out.

This means that clinicians can and should inform patients about lifestyle risks and offer screening and immunizations. This type of anticipatory care can enhance both health and autonomy. Many people would like to improve their health, for example by amending their diet, giving up smoking or taking more exercise, but are prevented from so doing by that weakness of will, or *akrasia*, which we discussed in Chapter 3. To give patients information on what changes to their lifestyle may help them to avoid illness and improve their health enhances rather than diminishes their autonomy. Clearly, for both practical and moral reasons such information needs to be linked to an offer of advice and help to reduce the risk of illness. Failure to do this raises needless anxieties, infringing the basic Hippocratic principle of *primum non nocere*. However, it must remain for the patient freely and autonomously to decide whether to accept or reject screening or help to modify his lifestyle. Health promotion in the context of patient empowerment demands an acceptance that the patient may use that power to make choices which we do not like.

Respect for autonomy does not prevent such work being encouraged by financial incentives or audited, but anything which encourages the doctor to pressurize patients must be avoided. If target payments depended not only on offering immunization to a given proportion of the population, but also on discussing the benefits and why they outweigh the risks, they would be legitimate because they would be based on doctor behaviour, not on patient behaviour. Similarly, an audit may study how extensively a screening procedure is offered to patients, so long as the audit is based on the offer of the screening rather than its acceptance.

In some instances, such as blood pressure measurement, the results are likely to be little different whether we measure offers or uptake. This is a convenient and almost painless test, free from embarrassment and not leading to a highly feared diagnosis; refusal is rare. For cervical cytology, testicular examination or mammography, however, results may be very different. It may be important to record and understand why patients refuse an offer of screening, so that fears and other obstacles can be tackled. However, it is not legitimate to conduct an audit in such a way as to encourage pressure on individuals to take up the offer. By separating the population perspective, with its utilitarian difficulties, from the anticipatory care agenda of individual patient care, it is possible to resolve much of the tension between the anticipatory care theory and our revised biomechanical/interpretative theory.

## Conclusion

This outline of an attempt to bring together the three models concludes the first half of this book. There is much more to be done in sorting out the detail of the relationship between different concepts of the human being, the nature of illness and the purpose of medical activity. Rather than pursue these further, the rest of this work will examine perhaps the most important implication of the synthesis attempted here: the need for a virtue theory of medical practice.

# Chapter 6

# The need for virtue

In recent years, medical ethics, like moral philosophy in general, has been dominated by the intellectual analysis of problems using consequentialist or deontological arguments. A coherent theory of what is right and why is vital, but it is over-intellectual and excessively optimistic to assume that it is sufficient to know what is right in order to do it. Another tradition in moral philosophy, dating back to Plato and Aristotle, is the study of virtue, or what it means for the *individual agent* rather than the action to be good. This was the dominant approach to moral philosophy from Plato to the Enlightenment. Although it has received little attention in past decades, it has recently undergone a renaissance. Several writers (Ellos, 1990; Pellegrino and Thomasma, 1993; Toon, 1993a) have suggested that it will meet some of the difficulties of purely intellectual approaches to medical ethics. The study of virtue takes account of human weakness (we do not always do what we ought to do) and of the non-rational elements in human nature - emotions, desires and the influence of physical factors on our actions.

Prior to the development of academic medical ethics, it was widely assumed in the medical profession that doctors acquired ethical behaviour intuitively, as a part of clinical training. Apart from a few rules, more matters of etiquette than of ethics, there was no need to consider or teach what was right as this was obvious to right-thinking, properly brought-up people - and only people of that sort were admitted to medical schools. Moral judgement was seen as an integral part of clinical judgement (which it is), subject to the same canons of scientific method (which it is not) and not able to be further analysed (which it can be).

A virtue theory of medical practice is very different from this. Although apprenticeship, tradition and modelling have their place, doctors also need a sound grasp of ethical analysis and a critical approach to the basis, nature and cultivation of virtue based on a sound meta-ethic.

## The definition of virtue

Thomas Aquinas, an important philosopher in the virtue tradition, defined virtue as "the habit or disposition of acting rightly according to reason" in *Summa Theologiae*. This means that we must both study what intellectual analysis tells us to be right (through use of "right reason") and acquire the personal attributes needed if we are to do the right things consistently ("the habit of acting rightly").

Right reason does not mean simply the intellectual understanding of the logical framework for deciding what one ought to do (the construction and teaching of which has preoccupied medical ethics in recent years). It also implies the intellectual skill to apply that framework to the individual case - casuistry, shorn of its pejorative implications of intellectual legerdemain. This skill of applying the general to the particular in the evaluative issues of medical practice complements the empirical aspects of clinical judgement.

The habit or disposition of acting rightly means that the practitioner, knowing what is right, will do it. Often this will happen automatically, without conscious thought, just as the experienced doctor instinctively asks the right questions and performs the necessary examinations to make a diagnosis. Sometimes it will require an effort of will, or the support of other people, or of structures.

## Virtue as excellence

It is important to be clear what we mean by virtue. The word has been corrupted in English in two ways. The first is through its use as a synonym for virginity, as in a young woman "losing her virtue". Although now rather archaic, this usage, like the analogous restriction of morality to sexual morality, still gives a sexual nuance to the term.

The second (perhaps related) distortion has arisen through the common equation of being good with being "goody-goody". Although the influence of this precious, pastel-tinted picture of goodness fades as time distances us from its nineteenth century origins, it still affects our understanding. Victorian images of "Gentle Jesus, meek and mild" (Wesley, nd), the pale Galilean at whose hands the world has grown grey (Swinburne, 1866), and popular moral tales (Turner, 1967) cast a long shadow. The notion that right action is rather wimpish and much less fun than wrongdoing persists, despite the efforts of writers as varied as Sartre (1944), Lewis (1945), Tolkien (1966) and Solzhenitsyn (1969), to give a more realistic image of evil as a negative, destructive quality, more often mind-numbingly dull or intolerably irritating than romantic. Virtue has serious image problems in a society where cream cakes can be advertised with the

slogan "naughty but nice", and where "wicked" can become a slang term of approval.

Urmson (1988) suggests that "excellence of character" is a better translation than "virtue" of the Greek word *arete*, which Aristotle uses for the concept. Urmson's expression avoids not only the confusing overtones outlined above, but also the link of virtue and vice to guilt and responsibility. My outline of the virtuous practitioner, which I shall begin in the next chapter, will describe the qualities needed to practise good medicine. However, the word "excellence" is itself potentially confusing since in some academic circles it has elitist overtones. The search for good qualities of character is not confined to some moral aristocracy, but is one in which all can and must participate.

## Application of virtue theory to medical practice

Pellegrino and Thomasma (1993) have attempted a comprehensive account of the virtues needed for the practice of medicine. They make many valuable observations about medical virtue, but their selection and characterization of the virtues is arbitrary because they do not locate their account of the virtuous practitioner within a meta-ethical framework. Virtues, like rights, can be used as a rhetorical soapbox rather than as a basis for coherent argument.

Ellos (1990) has also attempted to apply virtue theory to medical practice, this time using an historical approach, looking at the virtue theories of Plato, Aristotle, Aquinas and the Scottish Enlightenment rather than surveying a catalogue of virtues. Although he raises some interesting points, he poses more questions than he answers, and the structure he chooses makes it hard to see how to apply his insights.

These authors are writing for an American audience, addressing the challenges which face American rather than European doctors. If virtues are the qualities needed to act rightly in the face of the challenges of life, as Nussbaum and Sen (1993) suggest, then we must have a separate account for each culture, not because of cultural relativism, but because a doctor faces different problems in different cultures. Similarly, because medicine differs from other occupations, we need a particular account of the virtues of a good medical practitioner - distinct from those of a good lawyer, a good architect or a good carpenter, for example.

The peculiarities of the moral problems facing American medicine, particularly the consequences of the US market system for the allocation of health care resources (a system not found in Europe), limit the relevance elsewhere of American medical ethics writing. A glance at the US-dominated Internet newsgroup "talk.politics.medicine" shows how different American culture is, even allowing for the over-representation of extremists in open forums. Sustained threads with titles such as "doctors are the embodiment of greed" and "get government out of health care" would be unthinkable in a European debate. This, coupled with American ethnocentricity, noted not only in medical ethics (Toon, 1997) but even in US coverage of the Atlanta Olympics, means that Europeans must develop their own account for their own culture.

It is important not to overstate these distinctions. Since we all share a common humanity, the virtues will have common features across cultures and occupations. The closer the cultures and activities, the more similar are the virtues required. Midgley's example of the need for keeping promises in any functioning human society implies that honesty is a universal virtue. One cannot envisage a tolerable society in which systematic dishonesty is counted as a virtue. Precisely what it means to be honest, however, may vary from culture to culture and in different roles. Are social "white lies" dishonest? What about activities such as advocacy (including medical advocacy) which require that the truth be presented in the way most favourable to one party in a dispute (Toon, 1991)? What does it mean to be truthful when telling the truth "by degrees", as when we break bad news? What is the status of occupations such as espionage, which may require deliberate dishonesty within a narrow field of activity? Constructing a sensible virtue ethic requires that we consider these difficulties.

## Macintyre's theory of virtue

An important stimulus for the renaissance of virtue ethics in recent years has been Macintyre's *After Virtue* (1985), which provides a framework for considering the nature and cultivation of virtue. Unfortunately, clarity is not one of Macintyre's most striking attributes, so I shall outline his theory (largely in his own words), and then expand on it with some examples.

Macintyre suggests that we need a moral system which is not merely an intellectual theory of morality or even a set of individual characteristics, but also a social structure. His theory can be divided into two parts. The first is his hypothesis, outlined in Chapter 2, that a coherent moral tradition existed prior to the Enlightenment and has now been irretrievably lost, so that we live in a fragmented moral universe. The second is a meta-ethical theory. This sees virtue as central to moral philosophy - hence his title. Macintyre defines a virtue as "an acquired human quality, the

possession and exercise of which tends to enable us to achieve those good which are internal to practices, and the lack of which effectively prevents us from achieving any such goods." To make sense of that definition, we must understand two terms which he invents, and which are crucial parts of his theory: practices and internal goods.

## Practices

Macintyre defines a practice as "any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended" (Macintyre 1985; p.87).

He extends this rather legalistic definition and further defines his idiosyncratic use of certain words. A practice is "never just a set of technical skills" although "every practice does require the exercise of technical skills" (p.193). Rather, through participation in practices, "conceptions of the relevant goods and ends which the technical skills serve . . . are transformed and enriched by these extensions of human powers and by that regard for its own internal goods" (p.193).

He tells us that a practice "involves standards of excellence and obedience to rules as well as the achievement of goods" (p.190). Although "the standards are not themselves immune from criticism" and "practices never have a goal or goals fixed for all time," since "the goals themselves are transmuted by the history of the activity, . . . we cannot be initiated into a practice without accepting the authority of the best standards realised so far" (p.190).

A practice has an identifiable history, and "to enter into a practice is to enter into a relationship not only with its contemporary practitioners, but also with those who have preceded us in the practice, particularly those whose achievements extended the reach of the practice to its present point" (p.194).

## Internal and external goods

Crucial to his theory is the distinction between internal and external goods. For Macintyre, these differ in two important characteristics. First, "it is characteristic of external goods that when achieved they are always some individual's property and possession," and "characteristically they are such that the more someone has of them the less there is for other people" (p.190). External goods are "characteristically objects of competition in which there must be losers as well as winners." This is obviously true of material goods, such as money and other possessions which are gained through practices, and Macintyre categorizes these as external goods. He also classifies as external goods some non-material goods which have this characteristic, such as fame and power. In contrast, although internal goods are "the outcome of competition to excel", it is characteristic of them that "their achievement is a good for the whole community who participate in the practice"; the possession of them by one does not take them away from others, but enriches them. Macintyre's examples are Turner's transformation of the seascape in painting and W G Grace's advancement of the art of batting in cricket.

The other distinction is that external goods can be achieved through a practice irrespective of how one participates in it; often they are linked only contingently, not necessarily, to a practice. In contrast, internal goods can only be achieved through a sincere attempt to achieve excellence according to the rules (explicit or implicit) of the practice. Macintyre's example is of the child bribed by the promise of sweets if they win at chess. The sweets are external goods, whilst the pleasure that derives from playing chess well - "the achievement of a certain highly particular kind of analytic skill, strategic imagination and competitive intensity" - is a good internal to the practice. So long as the child plays only to get the sweets, it does not matter whether they cheat or not, as long as they win. Cheating, however, renders unattainable the internal goods of chess, namely the satisfaction of exercising the analytic skill and strategic imagination which are uniquely developed through practising that pursuit.

## The pursuit of internal goods

Examples of practices which Macintyre quotes include professions such as architecture and farming; sports and games such as football and chess; academic disciplines such as chemistry and biology; and arts such as painting and music. These disparate activities, for which Macintyre has to invent the generic term practice, have certain common characteristics:

- They are complex; that is, they are not just technical skills, although they may involve the exercise of a variety of such skills.
- They are coherent; that is, they have rules that are more or less arbitrary and more or less explicit.
- They are co-operative. Even if it is a necessary feature of a practice that it involves solitary activity

(as may painting, or scientific research, or even football practice or strategic planning), practices are things which are taught and which people discuss, argue about and often develop together.

- They have standards of excellence: it is not meaningless to say that someone is a good footballer, chemist, musician or farmer. Whilst there may be debate about what precisely it means to be good at X, if X is a practice then being good at it is a meaningful concept.

- Part of what it means to participate in a practice is to attempt to achieve these standards of excellence to the best of one's ability.

Miller (1994) points out that Macintyre drew many of his examples and much of his thinking on practices from activities such as games and the fine arts, which exist solely for their own sake - in Macintyrean terminology, for the sake of the internal goods achieved by participants and the contemplation of those goods by others. These Miller refers to as "self-contained" practices. He suggests that there are practices of another sort, of which medicine is clearly an example, which exist to serve social ends beyond themselves. He refers to these as "purposive practices". It is with practices such as these that we are concerned. They are commonly means through which people earn their living. Architecture is a good example. Although the need to earn a living (an "external good" in Macintyre's nomenclature) may be the ultimate reason why an individual participates in that practice and is not, for example, a sculptor or a full-time chess player, earning a living is not the only good which comes from being an architect. Architects, if they are to be fulfilled, must to some extent enjoy their work and gain satisfaction from it; part of this comes from of doing the work as well as possible.

Despite the recent prevalence in our society of the Thatcherite belief that money is the only motivation, this hypothesis does not explain most people's behaviour much of the time (Hutton, 1996). Even those whose jobs give them little satisfaction (and such jobs are often those which fail to meet Macintyre's criteria for practices) find their life improved and their burden eased by doing it as well as possible: as is often said, "You get out what you put in."

These rewards are Macintyre's internal goods. They are unique to particular practices, and their value can only be fully appreciated by participating sincerely and wholeheartedly in the relevant practice. In contrast, the attachment of external goods such as money, power or prestige to a practice is a matter of social custom, not of necessity. Doctors in Britain, in Russia and in the US are rewarded with very different external goods, but share in the same internal goods.

The same external goods can come through many different practices, and may be obtained whatever degree of commitment is put into the practice. Indeed, some cynics would argue that a characteristic of external goods is that they are unrelated to the excellence of the practitioner. Macintyre's example of the bribed child is slightly artificial as it is based on a 'self-contained' practice. With a purposive practice such as architecture, we see more significant and typical external goods, such as fame, power and money, become available to practitioners.

These external goods can be obtained in many other ways, but the internal goods of architecture are available only through the practice of architecture. Examples of these include the creation of beauty, the pleasure which comes from its creation, and the satisfaction which comes from producing neat solutions which make cost-effective use of space and materials. The architect who designs shoddy buildings may become rich and famous (at least for a while) but will not achieve the personal satisfaction of creating a new and beautiful building, nor advance the corporate understanding of how to solve architectural challenges. Thus we can begin to see how the pursuit of internal goods helps to distinguish between the virtuous and the 'vicious' architect. In short, to become a good architect (and, as I hope to demonstrate, a good doctor) requires the exercise of the virtues, as Macintyre suggests in his initial definition.

## Is medicine a practice?

Is medicine "a practice" in Macintyre's sense? If so, who are its practitioners, and what are its internal and external goods?

Medicine certainly seems to have all the characteristics which Macintyre attributes to a practice. It is complex (*ars longa, vita brevis* [the art is long but life is short]) and is a socially established human activity. It has a history in Western culture which stretches without a break to Hippocrates, in both its practical knowledge and its ethical standards. It is not just a technical skill, although it involves the exercise of many such skills. It is coherent, with both explicit and implicit rules, although as we have seen some of these lack clarity, especially at the borders. It is cooperative, and certainly is taught and endlessly discussed, argued about and developed amongst its practitioners. Despite recent changes in medical education (GMC, 1993), the training of a doctor is still basically an apprenticeship.

The would-be practitioner enters into a relationship with contemporary practitioners, and has to accept the authority of recognized standards of excellence and obey received rules, though the established clinician may expand and develop the tradition by challenging and even destroying those rules.

Despite the difficulties in defining the good practitioner, no one argues that this question is meaningless. The whole enterprise of medical education and assessment, membership and fellowship of royal colleges, of research and continuing education, mixed as the motives of its participants may be, is at least in part an attempt to achieve those standards of excellence. Medicine has clear internal goods - medical knowledge and skill, and their fruits in the improved health of the community - and there are few Macintyrean "practices" of which the words practice, practise and practitioner are so widely used.

## Has medicine broken down as a practice?

So well does medicine fit Macintyre's criteria for a practice that it calls into question his first hypothesis - that the basic social structures in which we conduct our moral discourse and cultivate the virtues have broken down, and that we have lost the traditions necessary to maintain practices in working order. Some think that to imagine that such a total loss of moral direction is possible presupposes moral relativism. There are erudite debates about whether or not Macintyre is a relativist (Horton and Mendus, 1994), but these need not concern us. The arguments against emotivism, relativism and moral nihilism were rehearsed in detail in Chapter 2, and it is unlikely that the situation is as bad as Macintyre makes out. We do, however, need to consider whether there is still the fundamental moral consensus in medicine necessary for it to function as a practice in Macintyre's terms.

Macintyre himself is ambiguous on the question. He uses it as an instance of a practice in *After Virtue*, but earlier (Macintyre, 1977) he suggested that our moral confusion is so great that the only way to deal with it is for each doctor to advertise his or her moral principles as they advertise their opening hours and scales of charges. This unrealistically donnish suggestion indicates his pessimism regarding the coherence of medicine as a practice in today's society.

Miller's concept of self-contained and purposive practices is helpful here. If medicine is purposive, then to achieve excellence in it means to be an excellent healer of the sick. If, however, it is self-contained, then excellence is measured by those standards which have evolved in the medical community.

If these two meanings diverge, so that for example excellence in spectacular operations of doubtful efficacy is prized above excellence in more mundane activities of proven worth, then the practice has undergone professional deformation and is a less good practice. The doctor who took an overenthusiastic birdwatcher's interest in disease, prizing a patient for his "beautiful physical signs" (Toon, 1994b; p.21) is an example of such deformation. Those who have had close contacts with medical "centres of excellence" will, I fear, have no difficulty in thinking of others.

The state of medicine in Europe suggests that although the coherence of its tradition may have been strained by the moral catastrophe that Macintyre postulates, its disintegration has not been as total as he implies. Medicine has no doubt been deformed by an overemphasis on technology and by our love-affair with the biomechanical model. This may have led to it becoming too self-contained and inadequately linked to its external purpose. These criticisms have been widely voiced both within and outside medicine (Illich, 1975; Heath, 1995; Kennedy, 1981).

No doubt, there are differences in emphasis and some particularly difficult areas, such as abortion, euthanasia and new technology. These naturally attract public attention and are the focus of debate. But they must not mislead us into believing that they are what medical practice is about. Its moral tradition remains essentially intact. Many statements about medicine have ethical content (BMA, 1980; RCGP, 1990; ESGP/FM, 1995) and command wide national and even international agreement. Many more areas of medicine are not the subject of great moral controversy. Indeed, in general there is probably less consensus about the empirical links between action and result than about values. Whilst some doctors overemphasize the external goods, most of them, most of the time, are motivated at least as much by the internal as the external goods of medicine. In most specialities in most European countries, those with the ability to practise medicine could have earned more money, fame and power in other careers. As with any human activity, the motives of those who practise medicine have probably always been a mixture of laudable and base, and there is little proof that things are worse now than in previous generations.

Macintyre's meta-ethical theory of virtue and his theory of the moral catastrophe are not logically interdependent. One can accept his view of practices and the cultivation of virtue without having to believe that the world fell apart irretrievably at the Enlightenment.

## General practice in context

So far, this chapter has dealt with medicine as a whole rather than with general practice. As pointed out in the introduction, although general practice is being used as the case study, most of the arguments apply to all branches of medicine. Macintyre describes practices as if they were all separate and distinct, but clearly this is not so. Singing and playing the piano are practices with unique features, but they also share many common features. They are, as it were, different species within the practice genus called "music". A society consists of a complex web of interlinked practices which form a changing and growing pattern, just as cultures are interlinked.

It is therefore a matter of arbitrary definition whether we define general practice as a specific practice within the wider group of practices which constitute medicine. I would suggest that it is more logical to consider that it is. Even though attempts to articulate its aspirations are disjointed, general practice is a common enterprise in which a tradition is handed on from older practitioners to younger ones, who refine and develop the tradition but also accept its authority. Attempts to set standards and define quality (RCGP, 1985, 1990) have usually tried to make overt what was already implicit in practice, rather than impose a new and external set of standards. Our search for philosophical coherence must continue to be developed from within that tradition and not be externally imposed from arbitrary principles, which however logical cannot be authentic.

## Are there specific medical virtues?

Nussbaum argues that the Aristotelian catalogue of virtues (Nussbaum and Sen, 1993) includes all the qualities necessary to meet the basic challenges of life facing people in any culture or position in society, including bad luck and death. If this is so, we will expect to find common human virtues. These features and the virtues required for them are related to the basic human needs discussed by Doyal and Gogh (1991). How does this thesis relate to Macintyre's view of virtues as intimately related to particular, culturally specific practices?

Although some challenges face all human beings, they are encountered to different degrees. The detail and context vary, and some of us escape some of them altogether. For example, we all need courage. In a subsistence society beset by hostile animals, the emphasis will be on physical courage. A different sort of physical courage is needed on an expedition to the Antarctic. In a bureaucratic or business world, moral courage to avoid pressure to do what is destructive and harmful may be more relevant. The fact that we use the word "courage" in these very different situations indicates its common features.

The differences in the challenges we face are partly a matter of luck (Nussbaum, 1986), but they also depend upon the practices which we choose or find ourselves engaged upon, since each practice has its characteristic challenges. The virtues required of their practitioners will therefore differ in two respects. The first is the extent to which a specific virtue is required. Patience, for example, is needed when dealing with children and the elderly; moral courage when caring for the dying. Other practices - for example theoretical physics - do not need these virtues with the same frequency. The second is that, although different practices may require the same virtue, its nature may be different. Thus the patience of a nurse caring for the sick differs from the patience of a silversmith performing a delicate piece of work, and the courage of a fire-fighter differs from that of a cardiac surgeon, even though there are common features in each case. Just as we saw that similar 'species' of practices can be grouped into 'genera' (and probably into classes, orders and phyla), so we can speak of different species of a virtue within the same genus. A person may excel at one species but be incapable in another.

Some virtues will have wide applicability. Just as skills like time management, verbal communication and the organization of data are relevant to a large number of trades and professions, and to some extent to all human life, so virtues such as courage and temperance are likely to be needed in a wide variety of practices in different cultures. The same will apply between different cultures. What it means to be a good mother may be quite different in an African village and an inner-city estate, but there will be a recognizable similarity in the virtues needed for motherhood.

## Must all virtuous practitioners be alike?

Reconciling the virtuous ideal with individual peculiarities is a general problem for virtue ethics. Descriptions of virtuous character often seem to describe a stereotypic individual whom all should emulate, a Platonic ideal of which we are all pale imitations. But the idea of perfect 'clones' is repugnant to many. Our brave new world, like Shakespeare's (*The Tempest*, V, I, 183), but unlike Huxley's (1950), is peopled by individuals whose perfection accentuates rather than blurs their individuality.

This is a particular problem for general practitioners who cling fiercely to their independence and value their idiosyncracies. A common concern, however unjustified, amongst general practitioner registrars

about the MRCGP examination is that success involves submerging personal views beneath an RCGP 'party line'. Underlying much of the resistance to recent developments and the low morale amongst general practitioners seems to be a fear of being forced into a mould not of their choosing (Samuel, 1990). How do we reconcile standards of competence and performance with individual idiosyncrasies?

All practitioners, no matter what their activity, are required to do certain things competently: we would look askance at a plumber who told us that he did not repair taps. General practitioners are required, by definition, to perform certain core activities competently; someone who lacks this competence is not a competent general practitioner. Someone who cannot perform these functions at all is not a general practitioner, even if they do other things excellently. Minimal competence in this core activity is the bottom line below which no practitioner can fall and continue to participate in the practice. Defining this core and minimal competence is not easy, but considerable advances have been made on both fronts in the past three years (GMSC, 1996; GMC, 1997). A clear link exists between (a) the suggestion in the previous chapter that the role of clinical medicine is to apply the biomechanical and interpretative functions to problems which fall within the range of convenience of the biomechanical model, and (b) the definition of core services being offered to those "who are or who believe themselves to be ill" (Spence, 1960; GMSC, 1996). The General Medical Council's performance review procedures (1997) could be taken to include virtue qualities in their assessment of that bottom line.

Above this bottom line, there is room for personal flair and inventiveness. We have seen that general practice aspires to more than one good, and the emphasis of individuals on various goods will differ. The range of practices which an individual is involved in will also affect his or her particular virtue profile. For example, I have at various times taken part in research, management, singing, writing, gardening, teaching, politics and philosophy, as well as general practice. My experience of each of these practices affects the way in which I engage in the others, and thus contributes to my own individuality. Genuine virtue builds on individual strengths rather than attempting to fit everyone into a mould. It is therefore likely to promote rather than suppress individuality.

A practice which attempted to produce virtuous clones would impose intolerable burdens in some areas, whilst limiting the potential for fulfilment in others. If part of the doctor's role is to help patients to develop and flourish as individuals, it follows from the principle of reflexivity that it would be iniquitous to prevent doctors from doing the same.

## Must doctors be especially virtuous?

The moral responsibilities of medical practitioners are often discussed in isolation from a general moral theory. Thus for Pellegrino and Thomasma (1993), "there is an implicit promise of some self-effacement of the physician's interests in favour of the patient's". Medicine is "a moral community" and doctors "have ethical obligations that transcend self-interest, exigency and even social, political and economic forces . . . They must concentrate on what it is to be a good physician and . . . what kind of person that physician should be." They argue that medicine is a moral enterprise because of the nature of sickness as a vulnerable state, the non-proprietary nature of medical knowledge, and the nature and circumstances of a professional oath. They see this as a buttress against the dangers of the consumer-business view of medicine. This argument, based on the belief that illness is a challenge in human life totally different from any other, leads them to place unique moral responsibilities on doctors.

Whilst illness can be a particularly vulnerable state, individual vulnerability varies according to the nature and severity of the illness, and not all those who consult a doctor are especially vulnerable. There are other vulnerable states, such as homelessness, extreme poverty, or unjust imprisonment. Even those in urgent need of the plumber are vulnerable, albeit transitorily. It is reasonable to suggest that those with more power have a particular responsibility to those who find themselves in such vulnerable conditions, but this is not specific to medicine.

The key to the argument seems to be the notion that medical knowledge cannot be owned. This is why the unique nature of illness as a vulnerable state intrinsic to the human condition implies "a moral claim on those equipped to help" (Pellegrino and Thomasma, 1993; p.36). Knowledge and skill are "internal goods", which as Macintyre points out are not limited resources: the fact that I gain them does not take them away from others. It is therefore true to say that they cannot be owned. This argument, however, applies to all knowledge, not just medical knowledge.

Although knowledge cannot be owned, acquiring it is expensive. Where higher education is free or heavily subsidized, one can argue that a doctor's acceptance of that training incurs a moral debt to society. Again, this applies not just to doctors but to anyone receiving a subsidized higher education. In the USA, where doctors pay for their training and run up substantial

debts in the process, it is reasonable to claim that they are making an investment rather than incurring a moral debt. In an educational market, knowledge and skill become commodities. Unless acquiring medical knowledge and skill is part of a unique 'deal' in which the doctor takes the knowledge in return for accepting the obligations, there is no reason why this moral claim is greater on doctors than on others.

Another argument for expecting self-sacrifice is that, by entering into the doctor-patient relationship, the doctor has promised it. Again, this is unconvincing. Contrary to popular belief, in many countries there is no formal taking of the Hippocratic or any other oath. Application to join the medical register does involve an implicit promise to abide by some common standards, but these are mostly of the 'bottom line' variety, designed to protect patients from being harmed by their doctors (GMC, 1995). Clearly, patients must be protected, and some behaviours render a doctor unfit to practise. It is hard to see how one could feel comfortable in entrusting one's health advice to a compulsive liar or exposing oneself to surgery performed by a serial killer. Here, the vulnerability of the patient to the dangerous doctor, and the unique importance of health to life does make a difference. Doctors must make a real effort to maintain that bottom line against temptation. This is essential, but it does not make medicine unique. As Pellegrino and Thomasma point out (p.36), similar efforts are required of all those whose work involves a position of trust and power over the vulnerable: firemen, the police, nurses and airline pilots, for example.

The expectation of special responsibilities for doctors is perhaps a result of applying the idea of vocation to a small group of careers, such as medicine, nursing and the priesthood. This is a notion which makes no sense outside a religious world view, for if there is no God with a plan for each of us, then who is doing the calling? Even within a religious view, it is a little strange. A God who calls people to be doctors and nurses but leaves the provision of plumbers, greengrocers and lawyers to chance seems neither to understand the varied needs of society nor to demonstrate evenhandedness between those whose lives he guides and others whom he leaves to organize their own careers.

To argue for moral responsibility on the grounds that health, illness and medicine are special is illogical and unhealthy, paving the way for unacceptable paternalism and moral superiority. Moreover, it is hard to see why anyone should wish to practise medicine as a livelihood if all it has to offer is an extra burden of moral responsibility. It is the 'heartsink' feeling of being given a load in excess of that borne by other members of society, without any concomitant reward, which seems to be at the root of the present crisis in the UK over morale and recruitment. The only tolerable basis for the moral responsibility of doctors is as a specific instance of a general moral requirement which applies to everyone: that one should do whatever one is equipped to do for those who are vulnerable. This is one of Kant's "axioms which one can wish to be a universal law" (Honderich, 1995; p.435).

Macintyre's view of practices and virtues provides a more general solution to this problem. A doctor has moral responsibilities not because there is anything special about medicine, but because anyone who engages in a practice has to fulfil its obligations to gain its internal goods. These goods are worthwhile for their own sake. As Slote (1992) points out, it is characteristic of a virtue that it benefits both the one who exercises it and the person towards whom it is directed. This is the major difference between virtue ethics and Kantian or utilitarian theories, which are concerned only with the effects of the agent's behaviour on other people. As well as the external goods which doctors earn from their activities (the consumer-business relationship), committed (virtuous) participation in a practice is rewarded by the internal goods of that practice. This makes virtue ethics reflexive in Kelly's sense of the term.

To seek only the external goods and do no more than the minimum required to keep out of trouble is not so much a failure of duty as a self-defeating strategy, just as those who cheat at games are self-defeating. If a sport is being played for money, or for an Olympic medal, then cheating may win the external goods, but it will deprive the participants of the internal goods proper to that sport. A view of life that values internal goods poses a challenge in a society which is obsessed by external goods, but which places much less value on those things which are hard to measure or are not measured (though not necessarily unmeasurable). Part of the solution is to measure these internal goods, a task which has been begun by researchers such as Bruster et al. (1994) and Howie et al. (1997).

As with any other practice, genuine and wholehearted commitment to the practice of medicine does make particular and specific demands. However, this does not mean that doctors need to be better than any other member of society; the demands are not greater than those of other practices, just different, and they are commensurate with the internal goods gained. Proper attention to its internal goods makes the practice of medicine an attractive profession rather than a thankless activity (Heath, 1995).

## Virtue and the wounded healer

The relationship between virtue and human weakness is a paradox. Although a weakness cannot by definition be a strength, vulnerability and awareness of one's own weakness can add to, rather than detract from, overall virtue. Arrogance, pride and self-righteousness are general human failings, and perhaps represent a particular risk in medicine, with its (largely illusory) impression of power over life and death. A little humility is a useful ingredient in the cocktail of medical virtues, and awareness of one's own frailty in not following what one knows to be the best advice for healthy living may add to the power of the "wounded healer" (Eliot, 1939) rather than detract from it. Furthermore, since an important aspect of the therapeutic relationship is empathy or compassion, frailties which place the doctor alongside the patient struggling with a problem, rather than in the position of a superior being, may be an advantage rather than a weakness.

## What does this mean in practice?

A concrete example of this difficulty occurs when the doctor's role includes giving health advice which they themselves do not follow. An editorial in the *British Medical Journal* (Chapman, 1995) suggesting that doctors who smoke are unfit to be general practitioners led to a heated debate (Sudbury, 1995; Ebdy, 1995; O'Brien et al., 1995).

As well as posing the "bottom line" question discussed above, this example leads us to consider to what extent a line can be drawn between the professional and the personal. The view that a doctor who smokes cannot be a good general practitioner assumes that one cannot advise one thing effectively whilst doing another, and that to attempt to do so is hypocritical. Others felt that it was unreasonable to require the doctor to be a paragon, and that giving professional advice did not necessarily require one to follow it oneself. This is a highly rationalist argument which splits the role of the intellectual practitioner from the rest of the person.

Behaviour is situation-specific, and the medical role is clearly defined. It is possible to imagine doctors who can split their responses according to the situation; for example, they might behave impeccably with their patients whilst being untruthful and inconsiderate in their private lives. How drastic a role dichotomy can be sustained is debatable. There must come a point when roles are so divergent that they cannot be sustained without damage to the personality, which itself renders the person unfit to practise. These are, of course, empirical psychological questions on which we can and should collect data.

However, it is more likely that such a role distinction could be successfully maintained in relation to an aspect of one's personality that is not central than in a core attribute such as truthfulness or consideration. Smoking may be such a peripheral behaviour. Doctors who smoke may be able to make and observe an absolute rule not to do so in their surgery, or in front of patients. There is a bottom line in this respect. Chain smoking in a chest clinic would probably demonstrate hypocrisy incompatible with a minimal acceptable level of virtue. The occasional cigar after a formal dinner, or a cigarette in moments of stress, might perhaps reflect humanity rather than hypocrisy.

Whilst doctors who do not smoke are better placed to advise others not to do so without hypocrisy, they risk being too remote from the situation and lacking empathy. One of the strengths of the self-help movement has been the power of someone who shares an understanding of a problem from the inside. One might argue that the best possible position is that of the ex-smoker who has quit after a great struggle, but who avoids the evangelistic zeal which so often characterizes converts and which can be so off-putting to those still outside the flock. But it would not be reasonable to require all doctors to smoke and then give up!

It may, however, be reasonable to expect the doctor who is a non-smoker or ex-smoker to be understanding of the pressures which lead people to smoke and of the difficulties in renouncing the habit, but to be zealous in offering non-judgmental help on how to achieve this difficult end. Similarly, we might ask that smoking doctors refrain from setting their patients an obviously bad example, and are no less zealous in helping them to give up. We need to know more about how these various behaviour patterns affect both doctors and patients before we can make a judgement.

## Who are the practitioners?

Macintyre's use of the word practice, normally used for what doctors do, naturally leads us to assume that it is doctors who engage in the Macintyrean practice of medicine. The doctor-centredness of the profession tends to reinforce that assumption. However, it makes more sense to see medicine (as a practice in the Macintyrean sense) as involving not only doctors but patients too, each participating in complementary but essential roles. There are many references (for example in Osler) to how much patients teach their doctors. Medicine exists "for the patient's good" (Pellegrino and Thomasma, 1988), as Miller (1994) also points out. If it does not serve this end then it becomes a deformed practice. It is, as Southgate (1996) put it, "a two-way street".

Medicine is not the only practice involving complementary roles. In the theatre, the actors quite clearly engage in a practice, with its tradition, its standards of excellence and all the other Macintyrean apparatus, but actors alone do not constitute theatre. Theatre is a practice in which we all participate when we form part of the audience, contributing to an active process which requires us too to enter into a tradition and accept standards of excellence, and through which we too achieve internal goods. Our role is different from that of the actors, but it is not that of passive consumers. Actors are well aware of the contribution the audience makes to their art, and will characterize audiences as good or bad according to how well they fulfil their complementary role.

Just as doctors who become too fascinated with the technology of medicine can lose touch with the purpose of their practice, so actors can become introspectively concerned with their own art, failing to relate to their audience and thus deforming their practice. Of course, it is also true that just as both actors and non-actors are potential audiences, we are all sooner or later likely to play the role of patient.

Thus, we see again that virtue theory is reflexive in Kelly's sense. Doctors cultivate their own virtues through the practice of medicine, and must do so if they are to practise satisfactorily. The sincere practice of medicine by doctors, in cooperation with their patients as they face the challenge of illness, also cultivates the patient's virtues. The roles are complementary, and the autonomy of both partners in the enterprise is thus enhanced.

This is not the place to consider the characteristics of the virtuous patient, but as we consider the virtuous physician it is important to bear in mind that we are describing only half of the picture.

## What are the internal goods?

Since medicine is a purposive practice, we have to define that purpose and its internal goods in order to define the characteristics of the virtuous doctor. The relevance of the discussion in the previous chapter may now be clearer. Seeing medicine as a cooperative practice in which doctors and patients play complementary roles makes it is easier to reach this definition. The goods which, as patients, we obtain from participation in the practice are clearly those of health - in both its hedonic and its interpretative aspect. We face the universal challenges of human morbidity and morality, and with the help of virtuous physicians triumph over them, either by ejecting the illness from our life or by using it to enrich our life narrative. Sometimes, our participation as patients is rather peripheral to our main story; but at other times, notably in terminal illness, the way we participate in the practice of medicine as a patient becomes central to the cultivation of our virtue as we face life's challenges.

The internal goods which the doctor receives and the virtues she acquires through participating in medicine are always likely to be very important to her, as our occupational practices play a central role in all our lives. These goods are associated with being a healer, and are developed in facing the challenges of that role. We will have a clearer idea of what this means when we have examined some specific virtues. As is traditional, I shall do this by giving an account of the particular qualities or virtues which characterize a virtuous practitioner. This will form the substance of the next two chapters.

Since it makes little sense to define the virtuous practitioner without some consideration of how we might make practitioners virtuous, the final chapter will seek to apply what we know about education and the psychological theory of learning to the cultivation of virtue, the third element to be added to knowledge and skills in medical education. This will also involve looking at the structures within which medicine operates to see how they support or discourage virtuous practice.

# Chapter 7

# Some observations on the virtues

For one person to attempt to describe the virtuous practitioner would be presumptuous, if not arrogant. It would reinforce the view that talk of virtue is moralistic rather than moral. Moreover, if the virtues are cultivated in a practice - a corporate activity - they must be defined by the joint efforts of practitioners, not by an individual. However, it would also be a little odd to argue for a virtue approach to medical ethics without giving any idea of what it might look like, and what difference it would make to the practice of medicine and the training of doctors. Medicine is a practical activity, but our discussion up to now has been rather abstract. In a spirit of Aristotelian compromise, therefore, I will neither be silent on the nature of the virtuous practitioner, nor attempt a definitive description of the virtues as they apply to medical practice. These observations are intended to illustrate the merits of the virtue approach and stimulate debate, rather than to draw a conclusion.

## What are the virtues?

To answer this question, we must first be clear what sort of a concept virtue is. Courage and temperance are not objects which exist in some mysterious way in the mind, as the amygdala or the pons are parts of the brain. This is to make the "category mistake" over the nature of mind which Ryle (1949) criticizes. Virtues, like other mental concepts, are constructs which we use to describe, analyse or explain certain patterns of behaviour.

Catalogues of virtue can therefore differ for two reasons. First, authors may really differ on what behaviours are desirable. It is possible to value different sorts of behaviour, even if our differences are limited by Midgeley's fundamental human moral consensus. More commonly, different accounts of the virtues support similar patterns of behaviour, merely categorizing them differently. The traditional cardinal virtues, for example, do not make specific reference to honesty, although as Midgeley points out keeping promises is fundamental in any human society. Within an account based on this catalogue, honesty may be considered under faith (because faith requires that we enter into trusting and trustworthy relationships) or under charity (since to tell someone the truth is a necessary consequence of respecting them).

This is why the issues dealt with in the first five chapters of this work are a necessary basis for an account of the medical virtues. We must have a philosophical framework for our catalogue of virtues. They are the qualities required for and developed by the practice of medicine, but without a meta-ethical framework they can easily be just a formalization of our prejudices. For Aristotle, virtues lay between the extremes of two contrary vices: the doctrine of the "golden mean". Courage, for example, lies between foolhardiness and cowardice. Whilst this is often the case, even Aristotle failed to demonstrate that the principle applied universally. As we have an alternative basis for virtue in Macintyre's work, we need not be concerned with this theory.

Another feature of virtue which Aristotle noted was its link to emotion. Again, we do not have to be constrained by Aristotle's enthusiasm for neat classification systems, which led him to try to fit each virtue to its specific emotion. The importance of cognitive labelling in characterizing emotion (Schachter and Singer, 1962) would in any case suggest that to attempt to do is futile . However, it is important to recognize that emotion is central to virtue, and that the use of emotion to support what is right, and the governing of it to avoid what is wrong, is a central aspect of virtue theory.

If the virtues are constructs, there will be many possible ways of cataloguing them. There is no merit in trying to shoehorn the qualities we value into an arbitrary framework. The traditional Christian system (catechism of the Catholic Church) of seven virtues divides them into four "cardinal" virtues (courage, prudence, temperance and justice) and three "theological" virtues (faith, hope and charity). This classification seems to owe more to numerological than to psychological considerations. Nevertheless, the system (or some close variant of it) is well established not only in religious but in secular moral thought, and it covers most of the issues we need to discuss. In the absence of any better system, I shall therefore use it as my framework. I shall deal here with courage, prudence and temperance, and then with faith, hope and charity. Because there is much to say about justice, as a principle as well as a virtue, I shall consider it in greater detail in the next chapter.

## Courage or fortitude

I have taken courage first for two reasons. First, although thinkers vary in their precise understanding of what it is to be courageous, some notion of courage is a feature of most accounts of the virtues. Secondly,

courage is an aspect of moral behaviour notably absent from consequentialist or deontological theories, and thus demonstrates particularly well the specific contribution of a virtue approach.

For the Greeks, courage was a fairly narrow concept, concerning behaviour in battle (Urmson, 1988). In our society, the need for such courage is fortunately rare, but similar qualities are needed in a variety of other challenges. Another label often used for courage is fortitude, which emphasizes the low-grade, undramatic but chronic aspect of the virtue; this aspect is particularly relevant to general practice.

Courage is traditionally divided into physical and moral. The courage required in medicine is mostly of the moral kind, but at least one problem in medicine requires a modicum of physical courage - the treatment of infectious diseases. In the past, this was a common hazard for doctors. Antibiotics and immunization have reduced the risk considerably so that most of us give the matter little thought. HIV is now the obvious untreatable infection to which doctors may be exposed, although in reality it poses little threat to the prudent medical practitioner. It does, however, illustrate some important features about medical courage. Courageous physicians strive to keep an Aristotelian mean between rashness and cowardice. This means that they do not refuse to examine or to take blood from patients for fear of exposure to HIV, but neither are they careless about the precautions required to avoid infection. Secondly, as is so often the case, many of the things we fear about HIV are irrational: the traditional fear of contagion associated in the past with plague and leprosy, and the stigma of the condition, for example. Many of us will admit that we instinctively recoil from potentially fatal contagion. Courage is often required to conceal or overcome these feelings, which can be so hurtful to patients.

There may be other instances of the need for physical courage - in war, for instance, or after serious accidents, when treating patients may put the doctor's life at risk - but for most medical practitioners the main risks we run are psychological and social, and the courage required is moral rather than physical. The following examples illustrate the need for moral courage in general practice.

*Case 1*
A patient known to be addicted to dihydrocodeine comes telling a highly dubious tale of how she has lost her prescription and is suffering severe pain. She is en route to a treatment centre, but needs a supply of her opiate to enable her to get there. She wheedles, cajoles and threatens. She uses intimidation and moral blackmail.

The doctor knows that almost certainly the real problem is that the patient's illicit supply has dried up. To issue a prescription will be of no help except to provide the most transitory relief, and may even do long-term harm by delaying the crisis which will help the patient face her problems. Furthermore, if it becomes known that the doctor is a "soft touch" he will have to face similar consultations with other patients, doing them little good and wasting time which could be more usefully employed. Nevertheless, to say no in such cases requires considerable courage.

*Case 2*
A patient attends on a busy January morning with symptoms of a cold, in the sincere but mistaken belief that these might be helped by antibiotics.

With a full waiting room, it takes courage to explain yet again that your refusal to prescribe is not a mean attempt to reduce your prescribing budget, but is in the patient's best interests. It is far easier to be the coward and reach for the prescription pad.

The action which perhaps requires most moral courage in medical practice is telling a patient of a fatal diagnosis and then staying with them, visiting regularly to offer symptomatic relief whilst watching the inexorable decline; or, if the patient is in hospital, not finding an excuse to hurry past the bed. We would gladly run away from these difficult tasks, but courageous doctors are able to face the patient's pain and mortality. In so doing, they can help the patient to face it, but perhaps also come some way to dealing with their own mortality.

These are just a few illustrations of how moral courage, or fortitude, is relevant to being a good doctor. Other examples might include coping with the "heartsink patient", dealing with the colleague who is not fit to practise, sectioning the violent psychotic, and risking one's job by "whistle-blowing" to expose poor treatment of patients. There are countless other examples.

## Prudence or practical wisdom

With our next virtue, we again encounter negative associations of a word, similar to those noted with the term virtue itself. We shall face this problem again when we discuss temperance and charity. Abstract words which each writer understands slightly differently are always difficult, but here the shift in meaning from the Latin is so great that the original and translated words almost represent different concepts. The Latin versions of these words were used by medieval philosophers to translate Greek words used by Aristotle and Plato with similar meanings, but they

put their own gloss on the Latin words. After the Reformation, when these matters were discussed in English, the meanings gradually shifted more as Protestant and then Enlightenment and popular Victorian interpretations attached to them.

Thus prudence in English, linked in sound though not in etymology to prude and puritan, has a rather mean-spirited feel to it, with overtones of avoiding trouble and keeping one's hands clean, in a way which tends towards the cowardice end of the courage scale. Pellegrino and Thomasma (1993) call it "a sickly concept". This is not the excellence of *phronesis* or *prudentia* which Aristotle and Aquinas discussed. Some writers, for example Urmson (1988), use the term "practical wisdom" as the best English term for the excellence of practical "common sense", which we all know to be far too uncommon, and not achieved without effort. Others, for example Pellegrino and Thomasma (1993), use the transliteration of the Greek word.

In our context, the virtue is often what is meant by "sound clinical judgement". From Aristotle onwards, this excellence has been recognized as a link between the moral and the intellectual excellences, and it falls into both categories. *Prudentia* is the capacity to link technical and moral judgement to achieve right ends. If we see virtue as a car, with charity as the fuel and courage as the engine, then *prudentia* is the steering wheel.

Pellegrino and Thomasma (1993) give an interesting account of this virtue as *phronesis*. It is "the capacity or disposition to select the right means and the right balance between means and good ends" (p.85). Our previous analysis shows that this is particularly relevant to achieving the right balance between the hedonic and the interpretative function, and between the externalization and the integration of illness. The capacity includes the problem-solving ability required for clinical decision making. Like riding a bicycle, it involves both the conscious and the subconscious mind, and depends on the emotions and the body being rightly ordered, which is why it is an intellectual excellence and not merely a skill. It also involves judgements on values, intimately intertwined with those empirical judgements, which makes it also a moral excellence.

The recognition of the dual nature of *phronesis* implies that, although we must appreciate (and when necessary) untangle the empirical and evaluative elements in our judgement, often it is not practical to do so. Often in clinical decision making, the experienced clinician (unlike the medical student) will not consciously go through the process of taking a complete history, examining the patient, making a full differential diagnosis, and proceeding by painstaking deduction to reach a diagnosis. Similarly, the virtuous practitioner need not solve every moral problem from first principles: a semi-intuitive process based on experience often produces better results.

Self-knowledge is an important aspect of *phronesis* which has often been neglected in medical education and practice. If a doctor does not understand her motivations, her tendencies to prejudice (which lead her to overdiagnose or underdiagnose certain conditions, as well as to judge people differently on grounds of class, sex, race or sexual orientation) and her own patterns of temptation, she will not be able to practise good medicine. Included in this element of *phronesis* is the awareness of one's feelings in the consultation and one's ability to use them as a diagnostic and therapeutic tool, as Balint (1957) describes.

## Temperance

This virtue too has negative associations, through its hijacking by the nineteenth century temperance movement, with a total abstinence from alcohol. The idea of such abstinence is itself an intemperate one, which led to the disaster of Prohibition. Perhaps Aristotle's idea of virtue as lying between two extremes most clearly applies to temperance. Strictly, temperance lies between self-indulgence or greed, on the one hand, and insensitivity to pleasure (or Puritanism) on the other. One might substitute the word "balance" for temperance as the label for this virtue.

For Aristotle, temperance was concerned solely with the bodily appetites - principally eating, drinking and sex (Urmson, 1988; p.67). It is helpful, however, to expand the range of convenience of the concept beyond physical pleasures to include all those activities in which human beings are tempted to excess (including excessive denial). In many practices, this includes finding a mean between an excess of work (correctly seen as an addiction for the "workaholic") and idleness. Temperance with regard to work is particularly important. Medicine in many parts of the world, including our own, is associated with a "macho" culture, in which to want to sit down, sleep or have lunch is seen as a sign of weakness; yet we all recognize that good practice requires attention to our physical and psychological needs. Tiredness causes irritability, and when excessive can lead to depression and poor judgement.

For the medical practitioner, there is also a specific mean between therapeutic nihilism and *furor therapeuticus*. In our culture, just as workaholism is a

more potent threat to temperance than idleness, so overtreatment and defensive medicine can beguile us; we need to be reminded sometimes of the virtue of mastery inactivity - "don't just do something, sit there" - a strategy which can win wars if pursued with sufficient courage (Tolstoy, 1869).

This is not to imply that temperance is not needed in the rather narrow sense in which Aristotle uses it. Doctors are in a peculiarly delicate yet powerful position with respect to patients, who are often emotionally vulnerable. Psychoanalysis has made us more aware of the strength of the erotic feelings which can develop in the transference and counter-transference of the professional relationship. Sadly, recent events have made us only too aware of the potential for sexual abuse which arises in close relationships. Doctors need powerful self-control, as well as *phronesis*, if they are not to confuse the forms of love necessary to effective clinical practice with the eroticism which can destroy it.

Another area in which doctors are challenged to show temperance is the use of drugs. Doctors are more than usually prone to problems with alcohol and have one of the highest rates of alcoholism (Anon, 1987; Juntunen et al., 1988; Baldwin et al., 1997). Misuse of the privileged access to addictive drugs provides a steady stream of cases for the General Medical Council. A stressful way of life, combined with easy access to drugs, provides a broad road to temptation.

Failures in temperance show particularly clearly that professional matters can be isolated from general life less than often assumed. Macintyre (1985) argues that one cannot be virtuous "just on occasions", and it is axiomatic that virtues should be general dispositions. Temperance in medicine certainly requires temperance in the whole of a doctor's life, not just in practice. The doctor who drinks too much, or who stays out too late and is not fit to conduct morning surgery, has failed in temperance just as much as the workaholic who cannot go home or the doctor who cannot resist the temptation to prescribe too many drugs.

## Faith

In the traditional catalogue of the seven virtues, faith, hope and charity are grouped as theological. This does not mean that they have only a narrow, religious importance, but it does suggest that they are not achieved by deliberate effort but are received as gifts by those who are willing to accept them. The distinction between virtues acquired by the will and those obtained less directly is explored further in Chapter 9.

Faith, although it has not been degraded (like prudence and temperance) into something unpleasant, is often confused with the quite separate concept of belief. Faith is not believing six, or even one, impossible things before breakfast (Carroll, 1865). It is the commitment to live according to the axiom that we should be seeking to live the good life. It is the overarching construct that determines our beliefs. Right actions and faith mutually reinforce each other.

As Grant Gillett (personal communication) has argued, there is no refuting the person who lauds evil and scoffs at good, and who prefers darkness to light, confusion to clarity, hatred to love, death to life; all we can do is assert that they are wrong, and sad. They are, in an extreme sense, outside our tradition and practice, in Macintyre's sense of the terms. There is, of course, such a perverse element in the best of human beings, as Freud (amongst others) points out.

Pellegrino and Thomasma (1993) point out that faith also involves "fidelity to patients". Trust is indispensable in human relationships. Without it, we could not live in society or attain even the rudiments of a fulfilling life (p.65). This is Midgley's point about promising: patients have to be able to trust doctors, which implies that doctors must show consistency of action and keep their promises. Doctors also have to be able to trust patients, and not succumb to the temptation to try to control them for their own good. Trust between doctors, and between doctors and other health professionals, is also vital. Such trust is often sadly absent in the rivalries between partners, between doctors in different specialties, and in the tribalism which can exist between the different health professions.

## Hope

To continue to practise medicine requires a minimal level of hope, namely the belief - often against all the evidence - that what one does is of some value. This relies on an underlying conviction in the possibility of inherent goodness in the world, that "all shall be well, and all manner of things shall be well" (Julian of Norwich [Backhouse and Pipe, 1987]), which is part of the overarching faith discussed above. Patients too come to the doctor partly to gain hope. One of the most difficult tasks in medicine is sustaining that hope without dishonesty when there is very little that can be done. Hope, like courage, is an infectious virtue; if the doctor can sustain it, then the patient too will benefit. To describe this virtue, it would be hard to do better than Dr Hainsworth (1997), a retired general practitioner:

*Following the retirement of my senior partner, who had served the village community for 35 years, patients*

*were now obliged to consult me, a relative newcomer of two and a half years. One such patient was an elderly woman with a moderately severe deformity of the hands due to osteoarthritis. As she was able to walk to the surgery, she had been a regular attender. She had been prescribed a full range of the drugs which were available at that time. Although I cannot remember precisely what I said, as I handed her the repeat prescription I told her that her previous doctor had given her the best medication then available and I could not prescribe anything better.*

*In those days, we did not have appointments and ancillary staff - patients came to the open surgery at their convenience. As a result, this patient went out of my mind and I did not see her again for some months, when she requested a home visit. To my dismay, I found that she was now quite disabled, with most of her joints affected by arthritis. I said that I wished she had sent for me earlier and her reply was, "When I last saw you, you told me that you could not give me anything better, so I saw no point in coming when the tablets were not curing me."*

*An essential feeling to be given by the doctor to every patient is "hope" and since that day I have tried to choose my words with care.*

Not only does this story illustrate beautifully the importance of the doctor in sustaining hope, often in the face of reason, but it also shows how important small actions, gestures or turns of phrase can be. The patient's pessimistic interpretation of a fairly casual remark had a devastating effect on her health. It also shows the importance of acting in a way that demonstrates all the virtues. Dr Hainsworth's laudable intention was clearly to be loyal to his predecessor. Sadly, the way he did that had the unforeseen effect of destroying the patient's hope.

We can consider the morality of these small actions only in the context of a virtue theory. Purely intellectual theories cannot deal with aspects of behaviour which are as detailed or as intuitive as those shown by Dr Hainsworth's story.

## Charity (*caritas* or *agape*)

Again, we have a problem over what to call this virtue. Neither of the obvious English words will do: love is confused with eroticism and the Hollywood romantic dream of boy meets girl, whilst charity is tainted by the self-righteousness of Victorian philanthropy, which made it a simile for coldness. Beneficence is too abstract and too patronizing, whilst the deliberate choice of a classical term sounds inappropriately elitist for this universal cement of all human relationships.

Beneficence is one of Beauchamp and Childress's principles (1989), and it seems obvious that medical practice should promote the well-being of patients. Despite this, it seems vaguely improper to suggest that doctors should "love" their patients. Partly, this is due to the erotic connotations of the word, and to the emotional reserve which characterizes British society and makes feelings unmentionable. The intellectual detachment of the biomechanic seems to make love a soft-headed rather than a soft-hearted thing (Mackenzie, 1997); although it is clear that good mechanics in a sense love the objects of their attentions (Persig, 1974). More recently, the business emphasis in medicine and the focus on prevention have not been compatible with love.

Lewis (1960) gives a helpful account of "the four loves". *Eros* is the sexual love which in our rather sex-obsessed society has made it hard to use the term in its other three senses. *Philia* is the love between friends, and *storge* the affection which makes family life possible. Each of these three loves can interfere with the practice of medicine. The possibility of abuse arises when *eros* is involved in a relationship which has an unavoidable power differential. This is seen not only in relationships between doctors and patients, but in other caring relationships such as those that exist in families, and between teachers or guardians and pupils; cases of abuse by priests, social workers and foster workers illustrate the point. *Philia* and *storge* too can interfere with a professional relationship, as shown by the difficulties which can arise when doctors treat friends and family.

*Agape* is the type of love which is relevant to the practice of medicine. Although all the forms of love must have a emotional component if they are to be genuine, *agape* is disinterested without being uninterested. For the doctor, *agape* has two functions. First, the doctor's genuine concern needs to be fuelled by *agape* if it is to be communicated with conviction to the patient. It supplies much of the motivation to act virtuously in medicine, and ensures the correct orientation of action. So important is the latter that St Augustine was prompted to say, "Love, and do what you will" (Cohen and Cohen, 1960). This expresses clearly the belief that right action springs not from itself but from an underlying orientation.

Secondly, the delight which the lover takes in the beloved, whatever form of love is concerned, is necessary to enable doctors to survive psychologically in their role. The procession of human misery and some of the less attractive features of human nature which daily reveal themselves in doctors' consulting rooms is so relentless that unless doctors can delight in their patient's positive features, and even learn to love and be amused, rather than infuriated, by human

frailty, then effective practice - and even continuing sanity - will be impossible.

Campbell (1984) describes the moderated love exhibited in professional caring relationships. Whilst there are real difficulties about the boundaries of this love (in particular, its separation from *eros* and *philia*, and the tension between love and temperance in setting limits to what one can do), the term moderation is confusing. As a Scottish Presbyterian, Campbell's first thought, no doubt, is of the role of the Moderator of the Church: the one who keeps it within bounds. However, the word also means to reduce in intensity (MacDonald, 1972). Although the love in the doctor-patient relationship must have boundaries (the doctor must be able to 'switch off' between consultations and at the end of the day), within those boundaries it must not lack intensity. If it is not whole-hearted, and in that sense unmoderated, the interaction is characterized by a synthetic concern, an artificial warmth, and formulaic caring statements as unconvincing as the hamburger seller's "have a nice day". If it is to mean anything to patients, and to be of any value to them or the doctor, it has to be genuine. Whether or not one accepts the Christian scheme of the virtues, let along its broader theory of salvation, St Paul's famous description of this virtue (The Bible; I Corinthians 13) is unsurpassed, and repays consideration.

Again, the attempt to deal with medical morality separately from general moral principles leads us into a cul-de-sac. Doctors (and presumably nurses and social workers, Campbell's other "caring professions") have to display love and cultivate the virtues more widely simply because love is a central part of what life is about for everyone - including, crucially, all the doctor's patients. Certainly, there is a difference between the person-centredness of the "caring professions" and other ways of earning a living, in which the relationship is more often with the impersonal universe. Nevertheless, a continuum exists between the professions that Campbell discussed and others, in which the work is related mainly to objects. Insofar as work contributes to human development, it is a field for the exercise of the virtues.

There is no need, therefore, to ask why the doctor (any more than the baker or the potter) must be altruistic. Each of them will gain the goods internal to their work by approaching it in an altruistic (or at least not self-centred) way, focusing on the internal rather than the external goods. Seeing a form of work simply as a means of producing external goods not only devalues the work but also misses the point of life. There are ways in which some work does not allow the development of internal goods, and all work - even medicine - can be reduced to a commercial transaction.

## Physical virtue

Although any virtue is to some extent holistic, with cognitive, conative and affective elements, the qualities considered so far all emphasize the mental rather than the physical. In Chapter 3, we saw that a satisfactory concept of personhood was to take seriously the body as well as the mind. The Greeks took the cultivation of physical excellence most seriously. If we are to develop a concept of virtue which we can use in general practice, and which embraces both patients and doctors, our account too will have to say something about physical virtue.

How then do we define physical virtue? Clearly not in terms of conventional beauty or of athletic success. These depend on what nature gives us rather than on what we cultivate for ourselves, and are therefore inherently elitist. Using Macintyre's definition, the goods internal to the practice in this context are the well-being of the body. "Looking after yourself" is the physical virtue which we cultivate to achieve this good.

If we are to take this aspect of our model seriously, we must apply it as much to the doctor as to the patient. Thus, the virtuous physician should seek to cultivate his or her own physical virtue, and should commend the same to their patients. In a comprehensive model of the person, we cannot legitimately have one party in a relationship acting as a mind and the other as a body. Even Kant (1724-1804) would not allow this, for if we wish a maxim to be a universal rule then it must apply to us also. (This argument raises some interesting points for male doctors urging their female patients to have smear tests and mammograms). This is not to go back on what was said about "the wounded healer" or to imply that doctors have to be paragons of healthy living. It is merely to say that it is sensible for doctors to try to be no worse than anyone else, even if they cannot manage to be any better.

In one sense, the cultivation of our physical virtue is simply the application of prudence to our own physical well-being. Attempting to eat a sensible diet, avoid smoking, use alcohol in moderation and take appropriate exercise are all part of physical virtue for everyone. If we have a weakness, then virtue dictates that we seek to strengthen the weak part, or avoid putting ourselves under excessive strain in respect of the weakness. Thus we find a place for prevention in general practice - for the doctor as well as the patient - in a way which avoids the danger, inherent in the population approach, of objectifying the person. In this sense, promoting prevention enhances rather than diminishes the individuality of the person.

# Chapter 8

# The theory and virtue of justice

Just allocation of resources for health care is a problem at three levels. First, what proportion of national resources should be devoted to health care, rather than to areas such as education, defence, transport and private spending? Secondly, what services should be provided from this budget? Thirdly, if more people might benefit from a service than resources allow, how should we choose between them? These three levels are not, of course, independent. Rationing at the second or third level is one solution to a stretched service; another is to expand it, at the cost of expenditure elsewhere. These options apply both to the service as a whole and to elements within it.

As medical technology makes possible treatments which even the most wealthy society cannot afford, the just allocation of limited resources becomes more pressing. Many societies are experimenting with changes to their health care systems in order to contain costs. Often these changes make decision making more transparent, which means that questions of justice can no longer be ignored or hidden.

The allocation of health care resources is not a medical matter but one for the whole of society. However, doctors have a particular role to play, both at the second level, where medical knowledge is needed to assess cost and benefit accurately, and at the third level, where it is hard to disentangle rationing from other elements of clinical judgement. Thus there is no area of medicine where doctors can avoid questions of justice. This is particularly true of general practice, in which doctors not only provide primary care but shape secondary care, partly through referral (the "gatekeeper role") but increasingly through fundholding and other forms of involvement in commissioning.

Despite this, theories of medical practice and health care organization, both implicit and explicit, frequently lack a coherent account of justice (Toon, 1994a, 1994b; Crisp et al., 1996). There is reluctance on all sides to engage in frank discussion on the rationing of health care. Euphemisms like "priorities in resource allocation" are preferred, and many still try to believe that the problem need not exist. Because of its association with cuts in services, the term "rationing" is avoided by consumers and providers, who feel that more resources ought to be spent on health care, and by politicians and managers, who fear that others will blame them for not providing these resources.

A frank discussion of justice cannot afford such coyness, and I shall use both the word and the concept of rationing quite freely. This does not imply that any particular view of the balance between health care and other spending is right, in our society or in any other. It is merely an acknowledgement that resources are finite, and that however much we fund health there would be unmet demand.

## What is justice?

In translations of the Bible and ancient philosophy, the description "just" sometimes means that a person is generally good or righteous. This usage must be distinguished from the specific habit of acting towards others in accordance with a coherent theory of justice; it is this second meaning with which we are concerned.

Justice has two closely related aspects - retributive and distributive. Retributive (or commutative) justice concerns the jurisprudential basis of civil and criminal law, and was widely discussed in classical philosophy; Aristotle's account of justice (*Ethics*, Book V) deals almost entirely with this issue. This aspect of justice impinges on medical philosophy most obviously in the question of illness as an excusing factor (Chapter 4) with its implications for forensic psychiatry But it is distributive justice that is the more relevant to the practice of medicine and will concern us in this chapter.

## The basis of just distribution

Justice generally means distributing goods between people either in equal shares or according to some relevant characteristic, such as merit, need, desert or temporal priority (Lucas, 1980). The traditional (though rather artificial) illustration of distributive justice is the division of a cake between a number of people. We may share it out in proportion to how hungry each person is (need), or as a prize for success in a quiz (merit); we may charge for each slice, giving the greatest portion to whoever pays the most (desert); we may give slices to people in the order of their arrival (temporal priority); or we may simply give everyone the same size slice.

In real life, the relevant characteristic varies according to circumstance. Examiners for GCSEs and university degrees make strenuous attempts to award qualifications according to merit. Although grades and

degree classes are not the physical goods we usually think of when considering just distribution, they are "external goods" which draw their value from their scarcity - a first class honours degree is worth having only because few are awarded (Gilbert, 1889). Thus the same principles of distributive justice apply to these as to more concrete resources.

A market economy is based on the notion that distribution according to desert is just. If I pay a certain amount of money, justice demands that I receive appropriate goods in exchange; conversely, if I perform a service I deserve a reasonable payment in return. The role of regulation in markets is to ensure that, as far as possible, rewards are distributed according to desert.

A variety of goods are distributed according to temporal primacy. "First come, first served" governs the allocation of returns at the theatre box office; those who arrive first at the bus stop are the most likely to get a seat; and peerages are inherited on the basis of primogeniture (although the justice of temporal primacy is here tempered by sexism).

An attempt is made to distribute some social benefits according to need. The 'points' systems used by local authorities and housing associations to allocate priority to subsidized housing is an example of such a strategy. Elsewhere, human beings are treated equally merely on the basis of their personhood. In Britain, for example, primary and secondary education and access to public libraries are available without charge or the requirement to demonstrate need or entitlement.

## What basis is just in medicine?

The examples above have deliberately not been drawn from medicine, but each characteristic can be used to determine the allocation of health care. Understanding these different bases clarifies some disagreements about priorities. If we see health care as a commodity, it should be allocated to those who can afford to pay for it, according to desert. Until the last century, this was the usual basis on which health care was provided, although there has always been a tradition of free, charitable provision for the poor. In the middle ages, this work was carried out by the monasteries; more recently, voluntary hospitals and volunteer doctors have taken up the task.

In many societies, however, including our own, health care is seen as too basic a need for it to be sold only to those who can afford it, and charitable provision is regarded as too haphazard to provide an acceptable safety net. This is the reason for state funding of health care in national health services or compulsory insurance systems. So strong is this consensus that even Margaret Thatcher was forced to reassure Britons that the National Health Service was "safe in her hands". State-funded systems need a basis for resource allocation. This basis can be need, merit or temporal primacy.

It would seem that a publicly funded system aims, however imperfectly, to make health care available to those who need it, but this is not entirely so. Disagreements about priorities can arise when people believe that merit should play a role. Thus, there is often pressure to deny treatment for problems seen as self-inflicted, or a grudgingness in providing it. Examples of such pressure are seen in the refusal of some health authorities to fund the removal of tattoos; in suggestions that those who continue to smoke tobacco should not receive treatment for the diseases which it causes; and in the antagonism frequently shown towards those who harm themselves.

Another example of the merit-based argument concerns the use of nicotine patches. These have been shown to be effective in helping people to stop smoking, and a study using QALYs suggests that if our aim is to increase quality and quantity of life, then it is value for money (Fiscella and Franks, 1996). Use of the patch should therefore be supported as "evidence-based practice", yet it has been made non-prescribable in the National Health Service. One explanation for this surprising decision is that since smokers choose to spend money on tobacco, they do not "deserve" to receive free patches, despite the potential health benefits. Instead, if they want to stop smoking, they should buy the patches - which cost about the same as the cigarettes they are replacing - with the money they save by not smoking.

## What is need?

Even if need is accepted as the only basis for just allocation, it is difficult to decide which problems need medical attention, and which individuals are in most need of help. The first step in access to health care is usually a presenting complaint, which reflects want rather than need. Not all who have problems which might benefit from treatment present themselves, and some of those who do are not in the greatest need. What does justice demand we do for those with wants but not needs, and how far should we go to seek out those with needs but not wants? The first of these questions belongs to the debate over charges for prescriptions, visits and consultations. The second prompts us to question the value of screening and case-finding: how empirically effective are they and how morally justified? What definition of needs should we accept? Do infertility treatment, psychotherapy and cosmetic surgery meet needs or wants?

### Illness as a proxy

One attempt to simplify the problem is to use defined illness as a proxy for determined need. The logic of the argument is this:

The health service exists to treat illness.
X is an illness.
Therefore the health service should treat X.

For example, it is sometimes suggested that hormone replacement therapy should be provided to post-menopausal women because their lack of oestrogen constitutes a hormone deficiency disease. Others might argue that it should not be provided because the absence of oestrogen after the menopause is normal. The problem here is that illness, as we saw in Chapter 4, is an evaluative concept which depends on personal expectations and fundamental values. The line one takes depends on whether ovarian failure is seen as a Fulfordian action failure or an integrated part of life history.

### Rationing by waiting lists

Another approach is to allow a rather generous definition of need, but then to ration provision randomly. Rationing by waiting list has a long tradition in the UK, since in a centralized system it tends to emerge naturally when demand outstrips resources. It treats all people equally, leaving outcome to chance factors such as where they live and when they fell ill. A more intellectually satisfying approach is to ration by lottery, but this method is rarely used in practice.

## Consequentialist and deontological approaches

Just as ethical theories can be divided into consequentialist and deontological, so can theories of justice. Either justice means maximizing the total good, taking no particular account of what individuals receive (the consequentialist approach), or it means that those who control access to health care resources have a duty to try to meet each individual's entitlement. Whether the basis of justice is need, merit or desert, it can be applied in either way. The consequentialist approach in health care is exemplified by the QALY, whilst Rawls's contract theory and Doyal and Gogh's theory of human need are attempts to develop deontological theories.

The QALY approach is a brave attempt to bring precision to the problem but it has its drawbacks. It can only be applied at the second level of resource allocation, to decide between different services. It cannot help us decide how much to spend on health rather than education, and it does not help clinicians to act justly when choosing between individuals. And as with any consequentialist approach, the individual is allowed to be sacrificed for the public good, although it has been argued (Williams, 1996) that QALYs are not necessarily limited to a consequentialist system.

Furthermore, some writers have suggested that the QALY approach discriminates against the elderly. If a treatment adds, say, two years of life on average to all patients who receive it, irrespective of their age, then the age of the person being treated makes no difference to the QALY benefit. But if the treatment offers a 10 percent chance of a complete cure, but otherwise no benefit, then a treatment for a condition common in younger people (leukaemia, for example) will yield a much greater benefit in QALYs than treatments for problems common in the elderly, such as bowel cancer. A similar argument applies to treatment for the disabled (Silvers, 1995): the quantity of life added by a treatment for disabled people may be high, but its quality will be seen as lower than it would be for more healthy people. These QALY features have been referred to as "double jeopardy".

Perhaps the most serious difficulty with the QALY approach is deciding how to adjust added life years for quality. This is essential if QALYs are to be used to compare treatments which cannot effect a total cure for a life-threatening illness. To assess quality of life validly, we must agree on what constitutes a good life, and how this is diminished by different sorts of suffering. For example, how does one compare the pain of arthritis with the misery of depression, or a life of blindness with a life confined to a wheelchair?

Generally, these judgements are made by a sort of opinion poll in which the views of various people are pooled to produce a final rating. Inevitably, these judgements are somewhat subjective. For someone whose life centres on artistic and intellectual pursuits, life after a treatment which gives her an extra twenty years of life but leaves her confined to a wheelchair may be one of considerable fulfilment; whereas for someone with physical and athletic interests, the quality of such a life may be much lower.

Who should decide on what constitutes quality of life in different situations, and against what criteria? In particular, how does one make such decisions from the fortunate position of having experienced none (or at most a few) of the disabilities to be compared, and how can one avoid self-interest? Not unsurprisingly, those who perceive themselves to be potential beneficiaries of a health benefit give it higher ratings on QALY questionnaires than do others (Richardson and Nord, 1997).

Perhaps the chief danger of the QALY approach is not the problems they raise, but the value judgements they conceal beneath a spurious air of objectivity. Papers often give a figure for "cost per QALY" in pounds, francs or dollars, which gives the impression of a gold standard against which the cost-benefit of medical interventions can be precisely quantified. Recent papers include such figures for activities as varied as screening and treatment for diabetic retinopathy (Javitt and Aiello, 1996), HIB vaccination (Livartowski et al., 1996) and use of antidepressants (Revicki et al., 1997). Those who scan abstracts on MEDLINE in the name of evidence-based practice may easily overlook the evaluative assumptions which lie hidden in these papers, and which are not always clear even on careful reading. QALYs may have a useful role to play, but like any clinical tool they have their limitations, and can be misleading if used incorrectly.

## Contract theories

A traditional approach to problems of political philosophy, including justice, is the idea of the "social contract". The best institutions and arrangements, so the argument runs, are those that we would freely agree to if we were to make a contract to join a society, just as we might make a business contract. Rawls (1972) has produced an influential version of this thought experiment. He suggests that just arrangements are those that we would agree to if we could decide how the world should be organized before we knew anything about how this would affect us personally; he refers to this state as "the original position". "No one knows his place in society, his class position or social status, nor does anyone know his fortune in the distribution of natural assets and abilities, his intelligence, strength . . . even their conceptions of the good or their special psychological propensities" (Rawls, 1972; p.12).

He argues that under this "veil of ignorance" people would agree to two principles. The first is equality in the assignment of basic rights and duties, the second that inequalities of wealth, authority and the like are just only if they result in compensating benefits for everyone, and in particular for the least advantaged members of society. The concepts of the original position, the veil of ignorance and the principles which follow are possible alternatives to utilitarian theory in assessing a just approach to health care decisions.

## A theory of human need

Although he works out many implications of his approach in some detail, Rawls does not consider how it might apply to health care. Doyal and Gogh's theory of human need (1991) is built in part on Rawls's theory, and we saw in Chapter 5 how these authors provide a possible framework for a view of medicine which values both the biomechanical and the interpretative functions. Since their work is basically a theory of justice, it seems reasonable to hope that it might also provide a satisfactory intellectual basis for our approach to justice.

As a deontological theory it avoid some of the problems of the QALY approach. Everyone has a minimal entitlement, and the logic of the theory does not force us to leave those already disadvantaged to die in misery for the sake of those better able to gain more QALYs. In contrast, linking allocation to criteria of basic human need gives priority to those who fall furthest below that level. Because it makes some clear evaluative judgements about the nature and purpose of life, such a system avoids smuggling in values under the guise of fact. As Doyal and Gogh suggest, one could reasonably imagine people agreeing to this system under Rawls' veil of ignorance. The theory has some clear and practical implications, for example that access to free and safe contraception is a basic human need because without it women are disadvantaged relative to men, a situation that no one would agree to under a veil of ignorance. Working out what its practical implications are is not always straightforward but it has potential to provide a deontological alternative to QALYs.

## The need for an intellectual theory

No agreement on a satisfactory intellectual theory of justice for health care is yet in sight. Even so, an understanding of the issues and the various attempts to formulate such a theory can be useful. Such an understanding prevents issues of justice being confused with empirical predictions of the effects of treatment; it also helps people to be clear about their assumptions concerning justice, even if they cannot agree on them.

## Justice as virtue

Even with a satisfactory theory of justice, resources would not be allocated justly unless decision makers at all levels consistently acted in accordance with it. The allocation of resources to health care, rather than to other areas of public or private expenditure, is a political matter in which doctors and other health workers rightly have no more influence than other members of society.

It is in the allocation of resources to individuals that the virtue of clinicians is crucial. We have seen that clinical judgements include empirical and evaluative elements. Both involve an attempt to balance costs and

benefits for various courses of action in an uncertain situation. This requires us to practise the difficult art of applying the general to the particular - in empirical matters by applying the results of research studies on groups to individual cases, and in evaluative questions by applying general moral principles to particular situations. It also requires us to predict the outcome of the possible courses of action. Justice is one of the many entangled evaluative elements in clinical judgement which doctors cannot avoid.

Clinicians often have to decide how to prioritize patients for treatment since demand almost always exceeds supply. Although clinicians might feel that in other situations they consider only the needs of the individual patient, it is hard to see how this could be so. The cost of treatment is an element in clinical judgement that is difficult to ignore even if it is known only approximately. Implicit rationing takes place as doctors adjust referral and prescribing criteria according to their perceptions of cost and benefit. Thus, there is no alternative to clinicians being virtuously just.

## Avoiding injustice

Although it is difficult to say what clinical decisions are the most just without resolving the problems of theory, instances of obvious injustice should be avoided. For example, clinical decisions should not be affected by race, age, sex, social class or sexual orientation, unless these factors happen to be empirically relevant to the problem in question, as when they are related to differences in prevalence or response to treatment.

There is evidence that race influences medical appointments inappropriately (Esmail and Everington, 1993, 1997). Since virtues are general dispositions, doctors who show favouritism to one ethnic group over another when offering jobs are quite likely to show similar bias with patients. Such prejudice is often unconscious, and it has been suggested that doctors' decisions and actions are subconsciously affected by a patient's education or social class (Kikano et al., 1996; Scott et al., 1996). It is by no means easy to avoid favouring those who are like us or, equally unfairly, overcompensating those who are different. Moreover, to treat everyone in the same way may not be to treat them equally if their needs are different (Fuller and Toon, 1988).

Particularly in general practice, clinical judgements may be further affected by our detailed knowledge of individual patients. We all have our personal preferences which incline us to give more time to one patient than to another, or to treat one more sympathetically. Often we are not even conscious of these factors, but they can easily affect our criteria for offering treatment or referral on grounds irrelevant to the problem in question.

Self-awareness is an important element in overcoming these preferences. Our understanding of what makes us like some patients and dislike others can be increased by methods that are well established in medical education, such as reflection on consultations, alone or in Balint groups, or using audiotapes, videotapes or role-play. Understanding these factors will help us to put them aside when they are not relevant to the judgement in question.

Since many of the factors which influence our judgements are unconscious, we also need ways to collect data on the justice of our clinical judgements, just as ethnic monitoring reveals unconscious racism in organizations. Monitoring the quality of justice is as important as other aspects of quality assurance.

## Justice and the gatekeeper role

The allocation of resources to different areas of health care has traditionally been fought out between managers and specialists. In the UK, general practitioners have always had some influence on secondary care through their gatekeeper role, which ensures that specialists see patients only by referral from general practitioners. This originated as a restrictive practice designed to protect the livelihoods of specialist and general practitioners, but it has increasingly been valued for its role in containing costs and making more efficient use of expensive specialist resources. Indeed, some countries which never had this principle, or where it has disappeared, have tried to introduce it into their system.

In recent years, it has been suggested that general practitioners should have more direct responsibility for resource allocation in secondary care as part of the NHS internal market reforms. One way of doing this is by fundholding, whereby a practice or group of practices is given a budget to purchase many secondary care services. Secondary care commissioning by primary care groups, an as yet ill-defined process by which general practitioners, with others involved in primary health and social care plan the purchasing of secondary care together, is being introduced as an alternative to fundholding. Considerable controversy has arisen over what part, if any, general practitioners should play in these processes (Stewart-Brown et al., 1996). Our discussion cannot therefore be complete without considering the involvement of general practitioners in purchasing secondary care.

Some of the doubts over fundholding concerned

Some of the doubts over fundholding concerned the way it was set up and whether its higher management costs were justified by increased efficiency. An important moral issue is the suspicion, whether justified or not, of private gain from public funds which arises when independent contractors can use savings from a health service budget on, for example, improvements in premises which they themselves own and from which they stand to benefit. Another moral issue is the possibility of a two-tier system, which has arisen from introducing fundholding alongside other commissioning systems. Multifunds and general practitioner commissioning systems avoid some of these problems, and other safeguards and changes in procedures could probably deal with the rest.

However, one moral issue is inseparable from fundholding and commissioning - the tension between responsibility to the individual patient and wider duties to society. Some general practitioners feel they should act solely as the advocate of their own patients and that involvement in the rationing of secondary care compromises this role. No system in which general practitioners are involved can avoid this tension.

## Different sorts of gatekeeper

Gatekeeping usually refers to the primary-secondary care boundary, but Heath (1995) points out that primary care physicians help patients manage three boundaries: that between the integration of illness into life experience, and its externalization; that between medicalization and self-management; and that between primary and secondary care. General practitioners can influence all three, encouraging or discouraging externalization of illness, dependency on doctors and medication and use of secondary care.

The decision taken depends in part on the balance which patient and doctor see between the costs and benefits of biomechanical externalization, as well as on the balance between individual benefit from treatment or referral and the costs to society. All three boundaries have financial implications and therefore concern justice as well as other moral issues. Focusing on the primary-secondary care barrier and linking it to the management of costs makes gatekeeping seem entirely negative, as thought it were intended to keep secondary health care away from patients.

This presumes that secondary health care is an undiluted good. But many general practitioners see it rather as a sometimes necessary evil from which patients should be protected where possible. Pellegrino and Thomasma (1980) make this clear when they suggest that the competent physician always acts as a *de facto* gatekeeper by the efficiency of her actions. "Diagnostic elegance and therapeutic parsimony" achieve maximum good at minimum cost to the patient. They contrast this with the "positive gatekeeper", who acts as an entrepreneur, increasing consumption of the "commodity" of health care resources. Doctors are encouraged to behave in this way in countries such as France or Australia, where fees are paid for particular medical actions, rather than there being a capitation fee for all care required during an illness or over a given period.

Although positive gatekeeping tends to increase costs, this is not the only or even the main case against it. As Pellegrino and Thomasma point out, it is harmful to individual patients. If (all other things being equal) health is better than illness, self-care better than medical dependency, and primary care better than secondary care, boundaries should be crossed from left to right only when there is clear evidence that the benefits for the autonomy and health of the patient outweigh the costs. Thus positive gatekeeping is always wrong. Avoiding overtreatment and unnecessary medicalization of problems is merely good medical practice. It is an application of the ancient principle of *primum non nocere* and the more recent fashion for evidence-based medicine.

## Gatekeeping and the patient advocate role

The more usual understanding of gatekeeping, valued in the National Health Service but condemned by Pellegrino and Thomasma (1980), is that it balances the good of society against that of the individual patient when allocating health care resources. Although Pellegrino and Thomasma consider that this compromises the doctor's role as the advocate of individual patients' interests, most UK general practitioners are happy with this traditional referral role. Many, however, feel that fundholding compromises their role as patient advocate, although others see it as a way of improving their service to patients. Some of those who oppose fundholding are in favour of general practitioner commissioning, whilst others consider that their advocatory role is compromised by any involvement in purchasing secondary care. Who is right?

This problem poses three questions. First, is it possible to act solely as advocate for the individual patient and to ignore the wider costs of treatment? Next, if it is possible is it morally desirable to do so? Finally, is there any moral difference between gatekeeping by referral, commissioning and fundholding?

## Is sole advocacy possible?

The way in which considerations of cost and justice are embedded in clinical judgements was discussed above. Since hardly any doctors have only one patient, judgements about a given patient will inevitably be made in the light of previous judgements about many others; indeed, clinical experience is vital to inform such judgements. Few clinical judgements are so precise that they can be criterion-referenced; most are peer-referenced. This suggests that it will be difficult if not impossible to ignore all considerations other than the interests of a single patient.

## Is sole advocacy desirable?

Even if it were possible, it would not be just to ignore the interests of other patients when making clinical decisions. An obvious example which affects all doctors is the allocation of time. Justice demands that we attempt to use it where it will do most good, resisting pressures to spend it where demand is greatest or to linger on comfortable cases. This implies bearing in mind the other patients whom we have to see. The more prudent we are, the better we will assess the severity of need and act accordingly; and the more courageous we are, the more we will avoid wasting time when we are not able to do any good.

The same applies to referral and prescribing decisions. Faced with a restricted budget for drugs, or a limit to the availability of a certain treatment, the virtuous doctor will assess as accurately and as justly as possible who can benefit most, and will set criteria accordingly.

## Advocate for my patients only

Whilst doctors cannot consider only the patient in front of them, temporarily ignoring everyone else's needs, it is possible to implement a weaker version of this position both in traditional referral systems and in fundholding. This is the view that general practitioners should consider only the needs of their own patients, taking no account of anyone else's, or of any needs other than those of health care. This is very much in accord with the idea of market forces: general practitioners act as consumers in a free market, vigorously pursuing the interests of their own patients with no regard for anyone outside this hallowed circle. Is this a principle that we would wish to support?

The veil of ignorance does not have to be very thick to prevent us knowing who our general practitioner is going to be. If all general practitioners fight vigorously for their own patients, showing no regard for anyone else, then as in any unfettered market the strongest will prevail. This will disadvantage those with less effective doctors. It is not something one would be likely to agree to in Rawls's original position.

Such relentless advocacy will also push up total costs, unless budgets are rigorously cash-limited. This too will not be to general advantage. Heath (1995) points out that both doctors and patients are also citizens. As such, they have interests beside health care. Different individuals will have different priorities, but under the veil of ignorance it would seem reasonable to opt for a system which balances health care and other basic needs. Thus it is preferable for general practitioners as "citizen-gatekeepers" to play their part in balancing the good of the individual against the good of all other patients, and also against broader social goods.

## Different levels of gatekeeper

It may be neither right nor realistic for general practitioners to try to opt out of involvement in health care rationing, but there are different ways in which they can be involved. These differ in their openness, in the degree of influence which the doctor has, and in the extent of the wider group whose interests are balanced against the individual's.

Whilst some argue for implicit rationing (Hall, 1994), most people feel that justice is likely to be better served by explicit criteria and transparent processes in decisions about resource allocation (Rawls, 1972). In this respect, fundholding and commissioning groups are a major step forward from the implicit and covert rationing decisions, disguised as clinical judgement, which marked the traditional gatekeeper function in the UK.

In traditional gatekeeping, it is hard to be clear what other factors, and whose interests, the general practitioner should balance against those of the individual patient, because the process is implicit and frequently unconscious. Fundholding makes it clear that the practice has to balance the interests of the whole practice population against the individual, but this is still a narrow group. One of the attractions of multifunds and commissioning groups is that they avoid the injustices between different practice populations which fundholding may produce. Much more could be done to make rationing open, for example by developing explicit prioritization policies and by making contractual arrangements public.

A characteristic of justice is that power implies responsibility. Thus general practitioners who are direct fundholders have more political influence over what is provided to their patients than those who

perform a traditional gatekeeping role; they also have more responsibility for what is not provided. If general practitioners wish to influence the services which are available to their patients, they must accept the corresponding responsibility.

## Factors other than justice

It is all too easy to talk of health care planning and rationing as if it were solely a matter of enlightenment rationality. Just political decisions, however, require us to recognize that the argument is also influenced by emotional factors. Some causes tend to grab the popular mind more than others - in advertising jargon they are "sexy". As a result, health care provision can be deflected from a just course. Children and acute illness are "sexy" in these terms, whilst the chronically ill, the elderly and mundane matters like efficient organization are not. The Oregon priorities (Blumstein, 1997) and the row over Child B, refused funding for a final long-shot bone marrow transplant by her health authority, illustrate how potent this factor can be.

Special interest groups which promote the "GPs ought (Toon, 1994a) also attempt to influence resource allocation. Organization such as the British Kidney Patients Association and the British Diabetic Association lobby vigorously for their members. Whilst this may be legitimate, it means that less well-organized and influential groups risk being less favoured. Providers also have interests in relation to their services, and will defend them; similar lobbying takes place on behalf of individuals. Some people are better skilled in the art of coaxing than others, and virtuous practitioners must be able to resist these persuasive voices, "wise as serpents and innocent as doves" (The Bible; Matthew 10: 16).

## Towards a more just model

This is not the place to attempt to design an ideal model for the purchasing of secondary care. Many factors must be considered apart from the moral position of general practitioners. Some of these factors have been mentioned above. Another is the centralization of power and the democratic deficit in all areas of NHS management. There is also a potential for conflict between decentralization and accountability and efficiency.

Systems of secondary care purchasing have so far been too doctor-centred, and the role of other health care professions and informed patient representatives should be considered. This debate cannot take place in isolation from the other issues considered in this work - the development of a clearer consensus on the boundaries of illness, responsibility for health care provision and the purpose of medicine.

## Justice for the doctor

Justice is usually seen as involving an agent, in this case the doctor, making decisions which affect other people. An aspect which receives much less attention is the justice that balances the needs of doctor and patient. Philosophers often write as if moral agents had no needs of any sort - financial, emotional or physical - only the duty to act rightly. Thus Singer (1979) argues that you should give to Oxfam rather than buy your own child a present, as the good thereby achieved would be infinitely greater than if the money were spent on yet another toy for a privileged child.

Whilst this may be logical, it is psycho-illogical, and there would be a bizarre coldness about anyone who could behave in this way. We act well or badly as much because we want to as because of our moral theory. Doctors, like other people, have needs which can and do sometimes conflict with the needs of patients.

## How much should a doctor do?

General practitioners' independent contractor status means that they make ethical decisions about the standard of patient care in relation to their take-home pay and time off. Do they carry out their own on-call work, or do they use a deputizing service or a GP co-op? Do they see patients on Saturdays? Do they let patients at the end of surgery go on pouring their hearts out, or do they shut them up and get home to dinner?

Our theory of justice and virtue has to include a definition of a doctor's legitimate needs, and a way of ensuring that doctors hold to a golden mean between neglecting their patients and becoming workaholics. Medicine has a culture of excessively hard work. Both prudence and justice require an accurate assessment of what is reasonable to expect of ourselves and when we are right to say "No".

## What is just clinical freedom?

Doctors are independent people who dislike being told what to do. This independence is justified in the name of "clinical freedom", which means that for doctors to act in the best interests of patients, they must not be too constrained by rules and regulations. There is some truth in this argument, for rigid systems benefit neither patients nor doctors, as Soviet medicine demonstrated (Toon, Vilks et al., 1998). But clinical freedom is easily used to justify self-indulgence and the pursuit of one's own interests.

Employment status has little effect on the balance between doctors' interests and the needs of patients and society. Consultants have been salaried since the start of the National Health Service, yet some of them have been able to concentrate their efforts on esoteric conditions or aspects of disease which are of little practical benefit (Douglas, 1977). Contractual obligations are less of a constraint on the pursuit of personal interests than is consumer pressure. Thus provincial district hospital consultants have always had to provide a service to an area, whereas teaching hospitals until recently had a less clear commitment to provide basic care; their consultants could spread the net wide for conditions they wished to see, whilst ignoring common problems on their doorstep.

General practitioners with an open door to a list of patients cannot select whom they see, but can nevertheless shape their work. The patient who attends with a problem which does not interest the doctor can be referred or not encouraged to come back, whilst the "interesting case" will receive more attention and be urged to make follow-up appointments. Patients need access to doctors who are interested in their problems. This has implications for the selection and education of medical students, and for the organization of medicine. We must try to select students who will become interested in psychiatry, orthopaedic surgery, general practice and the other fields, in the right proportions. We must also educate doctors so that they can retain an interest in common and important problems as well as in exotica. Doctoring has its chores, and it is essential if doctors are to perform these well that they have ways of maintaining their interest and enthusiasm.

A traditional view in medicine is that it is the rare which is interesting, and that doctors are pathological "twitchers" fascinated by rare diseases. A second popular idea is that medical gratification lies in the saving of life. There is no doubt that making an important difference to someone's life is very satisfying, but lives are saved less often than most people think, even in dramatic high-tech specialties. For most doctors, the rare and the dramatic are uncommon; this holds even for those in the most acute or esoteric specialties, for in tertiary care units rare diseases become commonplace, and in accident departments and intensive care units life and death crises become routine.

General practice has produced a number of antidotes to the problem of doctors' boredom. One is to focus on the patient rather than the illness, a strategy emphasized in the interpretative model. Another approach is to look at systems rather than individuals: much disease could be prevented, and in many cases the care available could be better organized. A third way of compensating for the tedium of routine work is to develop an interest in disease management, for example by organizing screening systems or anticipatory care. Individually and corporately, we must plan career structures which take account of doctors' just needs and thereby enable them to do the best they can for patients.

# Chapter 9

# The cultivation of virtue

Our final task is to consider how to enable the practice of medicine to flourish in the hands of medical practitioners who are developing the virtuous qualities needed for the successful and enjoyable practice of medicine. This is partly a matter of selecting students with the potential to develop the appropriate dispositions, and educating them accordingly. Politically, it is also a question of deciding what structures may encourage virtuous or vicious behaviour. This chapter will include some observations on both these areas.

## Virtues - congenital or acquired?

Virtues have traditionally been seen as acquired, as in Macintyre's definition (see Chapter 6). This is perhaps because virtue philosophers are concerned with how we can change acquired characteristics to improve ourselves and make our lives more fruitful. There is little point in lamenting our genetic inheritance. But in fact human dispositions are the product of an interaction between natural potential and experience. Some capacities appear to be innate, or at least achieved without deliberate training; for most of us, walking, jumping and seeing fall into this category. Others are much less likely to be learnt without a deliberate intention, and educational institutions and activities are set up to encourage their learning. Whatever the degree of deliberate learning, there are always innate differences in potential. Some people seem to learn things without effort; others have an enormous struggle. As well as differences in overall learning ability, individuals have particular strengths and weaknesses. One may find languages easy but be hopeless at ball games; another may have little facility except in the manipulation of numbers.

The same is likely to be true of virtue. Some people naturally have the disposition to be just, courageous and loving in the ways which medical practice requires - or at least they have the potential to develop these virtues. Hippocrates understood this: "For a man to be truly suited to the practice of medicine . . . the first requisite is a natural disposition, for a reluctant student renders every effort vain" (Lloyd, 1978). The search for such a disposition should influence our selection procedures at all levels, undergraduate as well as postgraduate, and will contribute much to the research agenda outlined in the Postscript.

## Knowledge, skills - and attitudes?

Selection may be important, but the main influence we can have on medical practitioners is through education. It is common to consider learning and teaching under the headings of knowledge, skills and attitudes. In this century, medical education has emphasized facts and the assessment of knowledge. Recently there has been a move to give more priority to the acquisition of skills, whether manual, social or intellectual GMC (1993). Medical schools now teach communication skills, run courses on clinical problem solving, and have clinical skills laboratories. Assessment bodies set and critical reading papers to test these skills.

In contrast, the third element in the educational trinity receives scant attention. For example, the Dutch method of general practitioner assessment concentrates on knowledge, with some testing of skills but not of attitudes (Van Leeuwen et al., 1997). Even the MRCGP examination, one of the most educationally sophisticated in the Western World, has found attitudes harder to tackle than knowledge and skills (Southgate, 1994).

This may in part be because the ambiguity of the word attitude, which can mean not only disposition but also posture or stance, especially a studied or artificial one (MacDonald, 1972). The implication of pretence rather than genuine achievement does not encourage educationalists to tackle this area.

There is also a gap between attitude theory and measurement. Psychological theorists define attitude as "readiness for attention, or activity of a definite sort" or as "individual mental processes that determine a person's actual or potential responses" (Ajzen and Fishbein, 1980). They consider the cognitive, affective and conative aspects of attitudes as predictors of actions, but make no presuppositions about whether we can verbalize them.

In practice, however, the study of attitude focuses on the construction and use of reliable self-report scales. Attitudes measured in this way rely too much on conscious awareness to be good predictors of behaviour, since much behaviour is determined by unconscious or preconscious factors Moreover this encourages a static view of attitudes, of limited use in education, where promoting change is the main concern. In contrast, research on skills has analysed the

acquisition of skills using realistic laboratory models - an approach a much greater relevance to learning. Research on attitude change and developing experimental models to study it is much harder.

However, perhaps the main reason for the lack of attention to attitudes in medical education is that whilst knowledge and skills can be value-free, attitudes are essentially evaluative. Values are central to our personal identity, and attempts to change them come close to our core constructs. This is often threatening and intrusive (Kelly, 1955). The prevalence of relativism and emotivism (see Chapter 2) also discourages any serious attempt to teach values.

## Knowledge, skills and virtues

Just however as knowledge without skills is impotent, so knowledge and skills without values are directionless. We need a concept which encapsulates our intuition that professional education should be more than the acquisition of a value-free corpus of knowledge and the skills to use it. This concept must include an orientation, which literally means not merely a sense of direction, but a sense of where the centre of the world is and how to get there.

Attitude does not work in this role because it is not really attitudes which concern us, but behaviour and the values which determine it. This is not just a question of attitudes, but of complex conscious, preconscious and unconscious factors. Emotions and cognitions are intimately related to each other and to our actions. Expectations, attributions, self-image and schemata are also important, and professional education needs to take account of these. Virtue, the disposition to act rightly according to reason, can incorporate all these. It leads us to the centre of cognitive-behavioural learning theory, rather than leaving us stranded in a conceptual cul-de-sac as attitude study does.

Because it consists in acting rightly (a behavioural concept), virtue - like skills - can be measured against operational criteria in standardized situations which mirror what will happen in real life. Unlike attitude, which is a purely intellectual concept, virtue acknowledges that performance is affected by non-rational factors such as emotion and motivation, and by somatic influences on the psyche. One might have an admirable attitude but behave badly because of anger, boredom or a stomach ache; if we are virtuous we do what is right despite these obstacles.

Virtue includes the important insight that we need to educate and assess the disposition of practitioners. Even if our reason cannot yet untangle all the moral problems involved, we know what that disposition should be: to seek what is "right according to reason". The linked intellectual and behavioural elements of virtue can be assessed, partly by scales similar to those which we might use to measure attitude, but also in behavioural analysis, by video review or by OSCE.

Is this an authoritarian view? In our society, there is much talk of moral decline and a lack of shared values. Some favour a return to a more authoritarian society with stricter punishments and an emphasis on "family" or "Victorian" values. This is not what I am advocating in calling for the cultivation of virtue.

Mulgan (1996) points out that effective moral education is not brain washing or the forced inculcation of a fixed set of principles. It not only fosters the ability to think rationally about moral issues, but also encourages greater sensitivity to other people's feelings, and the capacity to empathize with and motivate them - characteristics which he refers to as "emotional intelligence". He points out that these abilities are more closely linked to success in life than intelligence or academic qualifications. The cultivation of virtue therefore results in a widening of choice, increasing rather than decreasing personal autonomy. It certainly does not mean imposing a moral view on others against their will.

Mulgan also reminds us that doing nothing is not an option: "Governments can't help but influence people's morality. The messages they send through the curricula in schools, through how public services treat people and how political leaders live their lives, inevitably shape the moral climate." The same applies in medical education. The views that future doctors form during their training are influenced in three ways: by what is considered important enough to be put into the curriculum, and more significantly what is important enough to be assessed (Newble and Cannon, 1994); by the behaviour of their teachers and other senior members of the profession, whom consciously or unconsciously they adopt as role models; and by the way those individuals and the institutions in which they work treat patients. Whether we like it or not, therefore, we are training medical students in moral (or immoral) behaviour. Since, as Plato pointed out in his *Apology*, a considered policy is better than one arrived at by default, we should consider how best to cultivate the virtues in our students.

## Educational implications

To cultivate virtue, we must take precisely the same approach to the virtue requirements of practice as we do for knowledge and skills. The first step is to define, by consensus, a 'blueprint' of the virtuous practitioner;

the observations in the last two chapters are a starting point for that process. The next step is to design assessment procedures which reliably and validly test a student's attributes against this blueprint. This will not necessarily entail an additional layer of assessment, which will be a comfort to battle-weary educationalists, not to mention students. Much of what is tested in existing assessments, particularly clinicals, OSCEs and vivas is in fact virtue. Recognizing it as such will allow it to be assessed more thoroughly and in a less haphazard way, but this can largely be done with existing tools.

The curriculum also needs to be reviewed to ensure that it delivers the training needed to fulfil the virtue requirements of practitioners. Again, much of this is already under way, not least in the reforms set out in *Tomorrow's Doctors* (GMC, 1993). However, using the concept of virtue will give this process a clearer framework and a sharper edge. The final task will be to identify those characteristics of entrants to training (both at medical school and at postgraduate level) which indicate the potential to acquire the virtues needed for their intended role.

## Moral understanding according to right reason

Perhaps the most obvious change in medical education with regard to ethical matters in recent years is the introduction of courses where students are taught elementary principles of moral philosophy and how to apply them to difficult cases. Such courses were almost unknown in the UK twenty years ago, but most medical curricula now include teaching of this type (Boyd, 1987).

Understanding these principles and being able to use them is the foundation of *phronesis*, the reason according to which virtue is the habit of acting rightly. However, intellectual understanding alone is not sufficient to ensure the cultivation of virtue in medical education.

## The learning of virtue

If the virtues can be learnt, then theories of learning should be helpful in understanding how to acquire them. We are fortunate that the study of learning has been an important strand in psychology for most of this century. Various strands in learning theory can contribute to understanding the cultivation of virtue. Less obvious but equally fruitful sources of inspiration are psychotherapy, spiritual direction and the arts. Interestingly, many similarities occur in the approaches offered by these very different disciplines.

## Direct and indirect cultivation of virtue

Ways of changing behaviour can be direct or indirect. Behavioural approaches, such as conditioning, some skills learning and competence-based learning (Burgoyne, 1993) aim directly at defined educational goals. At the other extreme, activities like prayer, meditation and psychotherapy are remote from the behavioural goals which they might seek to promote, although each has a theory of how it achieves behavioural results - the action of grace, the stilling of internal noise or the resolution of psychodynamic conflicts. Some things can be learnt by direct acts of will, but others need such indirect approaches. Adams' (1982; p.58) whimsical description of how to fly shows how this works:

*There is an art, or rather a knack to flying. The knack lies in learning how to throw yourself to the ground and miss . . . it is the second part, the missing which presents the difficulties. One problem is that you have to miss the ground accidentally. It's no good deliberately intending to miss the ground because you won't. You have to have your attention suddenly distracted by something else when you're halfway there, so that you are no longer thinking about falling, or about the ground, or about how much it's going to hurt if you fail to miss it. It is notoriously difficult to prise your attention away from these three things during the split second you have at your disposal . . .*

Some abilities have to be crept up on from behind in this way, and are a by-product of some other activity, like self-knowledge or holiness. Singing is a good example. Underlying much voice training is the recognition that the singer cannot sing better solely by a deliberate act of will. Indeed, attempts to try too hard can destroy the very quality the singer is trying to achieve, producing tension in the vocal muscles which makes the sound worse rather than better. The effort of the pupil is often directed not so much at making a beautiful sound as at overcoming the obstacles to achieving it, Success involves receptiveness (but not passivity), allowing something to happen while accepting a lack of conscious control.

The acquisition of certain clinical skills is similar. Auscultation of the heart, for example, cannot be learnt by trying hard. Rather, students have to learn to listen carefully in a relaxed fashion; then gradually, without necessarily understanding how, begin to distinguish the sounds and make sense of what they hear. Both direct and indirect approaches are likely to be needed in the cultivation of virtue.

## Habit training - behavioural methods

If virtue is a habit then we should be able to apply what we know about the modification of habits to its cultivation. Conditioned reflexes are the most basic form of unconscious habit, and classical and operant conditioning the simplest forms of learning. Conditioning is often seen as authoritarian, as something imposed by a controlling person on a non-consenting victim (perhaps because it was first studied in experiments on animals). This image has been strengthened by the extreme paternalism of some behaviourists (e.g. Skinner, 1972), and by the use of behavioural techniques such as token economies on children and the mentally handicapped, whose autonomy is seriously restricted (Kazdin, 1977). But psychologists often teach behavioural techniques of self-control to fully competent clients (e.g. Ignatius Loyola [Corbishley, 1973; pp 22-4], who described a clearly behavioural method for eliminating a bad habit, and Kennerley [1997]).

Certainly, situations arise in which behavioural training could contribute to the cultivation of medical virtue. For example, using computerized medical records carries a threat to patient confidentiality if the clinician forgets to close the record of one patient before inviting another into the consulting room. Always closing the record when the patient leaves the room is the sort of virtuous habit which can usefully be cultivated by operant or classical conditioning. However, the impact of such simple methods is limited to small instances of behaviour in specific situations. Moreover, we are better skilled at extinguishing vices by such methods than at creating virtues. Ignatius used this method only for the removal of an unwanted habit or vice. For cultivating positive virtue, he developed more sophisticated indirect methods.

## Modelling

Modelling is a powerful method of learning (Bandura, 1971). In a practice like medicine, where learning takes place in a master-apprentice relationship, it is likely to be particularly important. Deliberately or unconsciously, students adopt the behaviour of their teachers. This has important implications for selecting teachers and placing students. We all know that the best teachers are not necessarily those with the greatest knowledge or research ability. It is vital for the practice of medicine that impressionable students are exposed not just to practitioners with excellent skills in clinical practice but also to those from whom they are most likely to 'catch' the virtues of good practice.

## Cognitive-emotional methods

Cognitive therapy has developed in clinical psychology to change maladaptive behaviour which harms or distresses the individual concerned or others. Through cognitive therapy techniques, we can learn how to use the complex relationship between thought and emotion to alter our moods by methods similar to behaviour therapy. The insights thus gained into the determinants of behaviour may perhaps be of use in cultivating the virtues. Cognitive techniques for anxiety management can help in cultivating the virtue of faith, whilst depression techniques are relevant to hope.

Such simple techniques, though effective, are limited. For the more extensive restructuring of the personality and the cultivation of positive virtues, less direct methods are needed. For example, analytic psychotherapy uses the exploration of the past. Other forms of psychotherapy, such as personal construct therapy and schema therapy, and even religious practices like Ignatian meditation, may also have something to teach us about the cultivation of virtue when we need to make major changes in our dispositions.

## Reflective practice

The importance of reflecting on one's practice as a prerequisite for professional development has been emphasized (Schon, 1983). A number of methods can aid reflection on the virtue of one's practice and promote self-awareness. Role-play and the analysis of recordings of clinical practice are increasingly used as both teaching and assessment methods. Situations which pose moral challenges (but not necessarily moral dilemmas) can be analysed from the perspective of virtue as easily as from that of skills and knowledge. A large part of Neighbour's work (1987) on the inner consultation can be seen as a reflection on the use of this approach to cultivate virtue for registrars in general practice.

Although the word is not used there, the literature of Balint clearly focuses as much on the virtue of the practitioner as on any other aspect of practice, and the Balint group offers an indirect approach to the cultivation of virtue. The work in the group is detached from and in many ways dissimilar to clinical practice, making the approach a fairly indirect one. Much emphasis is placed on the unpredictability and serendipitous nature of clinical insight, for example the "flash" (Balint and Norrell, 1973) and the paradoxical statement "don't just do something, sit there." It has much in common with the contemplative approach to virtue, particularly the Ignatian method (Sheldrake, 1991).

## The extension of our sympathies

An important if somewhat neglected means of education for medical practice is the use of the arts (Thomson, 1976; Calman and Downie, 1996). It would be difficult to express the rationale for this more clearly than George Eliot:

*The greatest benefit we owe to the artist, whether painter, poet or novelist, is the extension of our sympathies. Appeals founded on generalisations and statistics require a sympathy ready made, a moral sentiment already in activity; but a picture of human life such as a great artist can give, surprises even the trivial and the selfish into that attention into what is apart from themselves, which may be called the raw material of moral sentiment . . . Art is the nearest thing to life; it is a mode of amplifying experience and extending our contact with our fellow men beyond the bounds of our personal lot.*

(Dentith, 1986)

What Eliot calls moral sentiment is close to what we have called virtue.

## The virtuous life

Virtue is a matter of performance, not just competence. Like other types of performance, it depends on the general state of our lives as much as on specifically medical abilities. If we are tired, depressed, hungry or anxious, then we are likely to treat patients less well. Therefore, ensuring that we eat properly, are not overstressed and get enough sleep are as much matters of virtue as being able to give unpleasant news courageously or being just in our referrals. Techniques of life-planning and time management can help us to avoid being overtired or overstressed. Learning and using relaxation or meditation techniques to quieten the mind and body can help maintain the inner peace needed for virtuous practice. Applying a virtue approach in this way forces us to break down the artificial barrier between personal and professional life and to see the doctor, like the patient, as a whole person.

Although these methods are foreign to the tradition of medical education, growing recognition among doctors (e.g. Chambers, 1997) of the problems caused by stress has led to initiatives which include these kinds of activity. As they seem to be effective in common situations, perhaps they should form part of the core education for all doctors.

## Structures which support virtue

Personal characteristics are certainly central to a virtue approach, but it is a mistake to see virtue solely as matter for individuals. Human beings are social and political animals, and the virtue of individuals depends to a considerable degree on the institutional and organizational structures of the societies in which they live. Aristotle recognized this, and his *Ethics* and *Politics* are complementary volumes. Pellegrino and Thomasma (1993) suggest that medicine is a moral community of which doctors are a part, an idea very similar to Macintyre's theory of practices. How we organize our moral community or practice will affect how virtuous we are as doctors. The structural issues relevant to virtue can be considered under three headings: payment systems, safeguards against unacceptable behaviour (that which falls below the "bottom line"), and systems which encourage mutual support and a culture of virtue. These are mutually interdependent and also relate to the cultivation of individual virtue through education, as discussed above.

## Systems of reward for individuals

Although internal goods are important, the way in which external goods are linked to practices has a considerable effect on how they function. The effect of payment systems on medical practice is a good example of this. There is no right answer to the question of how doctors should be paid, merely a variety of answers that are wrong in different ways. Systems of capitation payment encourage doctors to avoid unnecessary procedures and superfluous investigations. This can lead to beneficially parsimonious practice (Pellegrino and Thomasma, 1980). But parsimony can easily lead to meanness. The surgeries of the 1950s, with their chilly waiting rooms, furnished with hard benches and out-of-date magazines, were witnesses to the dangers of encouraging parsimony to excess. These surgeries were replaced by more welcoming facilities under the reforms of the General Practitioner Charter of 1966, which introduced financial incentives for doctors to invest in premises and staff.

In contrast, items-of-service payments encourage positive gatekeeping. International comparisons between countries such as France, where doctors are mostly paid per consultation, and those where payment is largely by capitation make plain the difference between the two systems. In the UK, night-visit payments were increased in 1990 to what at first sight seemed a realistic rate for the job. There followed a rapid increase in demand for out-of-hours calls, which became an intolerable burden for practitioners. Around the same time, the ill-conceived scheme for health promotion clinics produced an epidemic of activity, much of it of doubtful benefit.

Item-of-service payments are effective at maximizing health care; but this is not the same as maximizing health, which is the aim of a rational health service. In some areas (immunization, and more arguably cervical cytology), the two may coincide. In such cases, simple item-of-service payments or target payments (a modification of item-of-service fees) may be the right way to encourage good practice. More often, performing the gatekeeper function properly at all the boundaries (Heath, 1995) means promoting autonomy in dealing with minor and self-limiting sickness, and discouraging unhelpful externalization of problems that are better construed in other ways; these actions are just as important as encouraging people to seek and accept care if they could benefit from identifying their problems as sickness. Balint (1957), writing under the capitation system of 1950s Britain, described the effect of this "apostolic function" on the approach to minor viral illnesses.

Systems in which doctors are paid to provide a service and take the profit as their income encourage efficiency in the organization. However, they must be carefully designed to avoid perverse incentives. The present system of paying general practitioners in the National Health Service has some serious flaws in this respect. The financial advantages of offering a minimal service to a large list, the considerable benefits from removing or not registering children whose parents decline immunizations, or women who refuse cervical smears, are examples of such perversity. "One cannot pay doctors to behave as captains of industry and expect them to behave like platonic gentlemen" (Toon, 1994a).

The third way to pay doctors is to give them a salary, like other employees. In the UK, not only are salaried general practitioners expected to become more widespread in the near future (Department of Health, 1996), they exist already as assistants in general practice and at all levels in NHS hospital practice. Salaried payments encourage neither activity nor inactivity, since the payment for the job depends on the hours worked. Managing the level and pattern of health care activity and ensuring efficiency becomes someone else's job. This does not, however, mean that it is necessarily the right solution; it may be that only clinicians are close enough to the patient to perform this role effectively, and a salaried service will allow the matter to be decided by default.

## Non-financial rewards

One of the mistakes of Thatcherism was the belief that behaviour, particularly professional behaviour, is solely or even principally determined by financial rewards (Hutton, 1996). Power, prestige and the esteem of those one respects (both patients and colleagues) are powerful motivators, as are the internal goods of the practice. Structures which encourage virtuous practice through these incentives are important; fortunately, they are receiving more attention. Awards such as Fellowship of the Royal College of General Practitioners by Assessment (RCGP, 1995; Moore, 1998), the Kitemark for practices, and activities such as the King's Fund organizational audit and the College's Good Practice award all seek to encourage excellence, not minimal standards.

We need a range of such rewards so that there is always a challenge with a non-material external good to complement the internal goods of virtuous practice and to encourage practitioners to aspire to such practice. At present, these rewards are rather ad hoc, and each has its peculiar strengths and weaknesses. Fellowship by Assessment rewards the individual general practitioner, even though much of the effort required comes from other members of the practice team. Applying for and maintaining the Kitemark is expensive and beyond the means of many smaller practices. None of the awards has a coherent approach to virtue, and there may be merit in a more unified and easily accessible system. Revalidation offers the possibility of this if it can be made a system of positive encouragements rather than a depressing and bureaucratic burden. Whatever system is adopted, it is essential that the criteria are derived from clear blueprints of the virtuous practitioner and virtuous practice.

## Guarding the bottom line

No matter how good our selection, training and assessment procedures, there will always be those who "slip through the net" or after some time in practice fall below acceptable standards. Our safeguards for dealing with these problems must cover deficits in virtue as well as in knowledge and skills. In the UK, the General Medical Council is responsible for providing these safeguards, through their procedures for unprofessional conduct and sickness and the recently introduced professional performance procedures. Much of its *Duties of a Doctor* (GMC, 1995) concerns minimal standards of virtue rather than knowledge or skills, and a beneficial by-product of the work on performance assessment may be better tools for the measurement of virtue.

The same considerations apply to the other fences at the bottom of the performance slope - complaints procedures, health authority service committees and legal action through the civil courts. However, the failure of these processes to address virtue adequately is part of the reason for the mismatch between what

they can deliver and what patients want from them. For example, patients often complain of persistent rudeness from their doctors. Such behaviour obviously falls below the minimal standards of virtuous practice, but the current procedures have difficulty in tackling it.

Bottom-line procedures must be viewed with caution. People do not function well under the influence of fear, and certainly one cannot compel people to be good. The National Health Service, like any other organization, runs most effectively when there is a large fund of goodwill from those working in it. Excessive use of bottom-line procedures risks exhausting that treasury. We can see the effect of this in the USA, not only in expensive and futile defensive medicine but in the hostile attitudes which both doctors and patients too often appear to bring to the consultation.

It is a well-established psychological principle that punishment is a less effective influence on behaviour than reward (Skinner, 1904-1990). We need positive incentives to motivate most doctors most of the time. Sanctions must be used only where more positive methods are not effective. Even when bottom-line procedures are needed, they should where possible be formative rather than destructive, building on whatever foundations for virtuous practice exist, and modifying vicious behaviour in the light of reason. Only where all hope of improvement is lost should such procedures be punitive.

The idea that patients are also participants in the practice of medicine is particularly relevant here, and it has been fairly suggested that doctors should have a reciprocal right to complain about patients who behave unreasonably. A new Patient's Charter, more balanced in this respect than the old one, has been promised.

## Encouraging a community of virtue

Peer pressure has a far greater effect on our behaviour than most of us would wish to believe. If social norms in our community support virtuous behaviour, it is considerably easier to behave virtuously. Conversely, only the most heroic can remain virtuous in a culture where vicious behaviour is the norm, as totalitarian cultures have demonstrated.

In medicine, this applies not just to major faults such as human experimentation in Nazi Germany, but also to more minor - but more widespread - examples of poor treatment of patients. For example, in many clinics timekeeping is not highly regarded. This makes it difficult for people who value punctuality to maintain their good habits. In addition, the lack of respect for patients implied by needless unpunctuality tends to generalize to other aspects of behaviour.

As well as creating a virtuous culture for everyday practice, we also need to shape institutions which encourage and 'envirtue' those who participate in them. Mentoring systems, learning groups, College faculties and group practices are examples of structures which can strongly encourage virtue, but which can have a neutral or even negative effect if they are dysfunctional.

Cultural norms in organizations have to be actively managed to ensure that they promote rather than discourage virtue. This does not imply some sinister form of social engineering, but merely the recognition that organizations have cultural norms which have an effect on the individuals working in them. It is better to determine openly the norms we would like to see, and encourage them, than to expect them to emerge spontaneously by benign neglect.

# Postscript

# Towards more virtuous practice

The establishment of virtue as an important aspect of medical philosophy and the links that this implies between facts and values indicate a substantial philosophical and empirical research agenda. First, we need to establish more clearly the nature of medical virtue. Whilst moral truth is not established by opinion polls, discovering the consensus of those within a moral tradition is an important stage in refining our moral theory. This consensus must then be tested philosophically for its consistency and rationality, and the credibility of its fundamental values explored. When fed back to the medical community, the results of this testing will further inform and shape the moral consensus. This iterative process has no end since the external environment in which the tradition develops is constantly changing.

Our first task is to explore in more detail the characteristics of the virtuous practitioner (particularly the characteristics needed in different specialties and at different stages in professional development, an issue which has not been tackled in the present work). One way of doing this is through individual reflection on observations such as those made in this book, and those which individuals draw from clinical practice. Although medicine is not simply a science, it shares many characteristics with the sciences; and it is through individual contributions shared in community structures such as conferences and journals that these practices develop, despite the limitations of these media (Lodge, 1989). Another way of improving our understanding of medical virtue is by finding ways of collecting the views of patients as well as of experienced practitioners.

Since to understand virtue is to understand why we behave as we do, the methods used by Balint and others to study the consultation process and the doctor-patient relationship may also improve our understanding of the nature of medical virtue. In many cases, this is already happening. Practitioners, like Jourdain in Molière's *Le Bourgeois Gentilhomme*, are discussing the virtues without actually using the term. Ideas of virtue permeate recent publications of the General Medical Council and the Royal College of General Practitioners. Consciously developing a virtue account of medical practice will help to draw this work into a clearer framework.

Our second task is to evaluate empirically the effect of different educational experiences on the characteristics of the virtuous practitioner. What is the place of cognitive and experiential learning in producing the virtues necessary for good practice? What are the best methods of assessing virtuous qualities? How can one fairly select for training those candidates who have the potential to acquire the necessary virtues? All these and many other difficult questions will have to be researched in the continuing pursuit of virtuous practice - for our good and for our patients' good.

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