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Toward a Virtue-Based Normative Ethics for the Health Professions

ABSTRACT. Virtue is the most perdurable concept in the history of ethics, which is understandable given the ineradicability of the moral agent in the events of the moral life. Historically, virtue enjoyed normative force as long as the philosophical anthropology and the metaphysics of the good that grounded virtue were viable. That grounding has eroded in both general and medical ethics. If virtue is to be restored to a normative status, its philosophical underpinnings must be reconstructed. Such reconstruction seems unlikely in general ethics, where the possibility of agreement on the good for humans is remote. However, it *is* a realistic possibility in the professional ethics of the health professions where agreement on the *telos* of the healing relationship is more likely to arise. Nevertheless, virtue-based ethics must be related conceptually and normatively to other ethical theories in a comprehensive moral philosophy of the health professions.

> If he really does think there is no distinction between virtue and vice, why, sir, when he leaves our house, let us count our spoons.
>
> Samuel Johnson

INTRODUCTION

IN HIS HIGHLY INFLUENTIAL WORK, *After Virtue*, Alasdair MacIntyre (1984) details the decline of virtue-based ethics since the Enlightenment and the obstacles to its restoration absent a community of shared values to sustain it. In this essay I shall start with MacIntyre's conclusions and examine the possibility of a restoration of virtue-based ethics to normative status in ethics generally and, more specifically, in the ethics of medicine and the health professions.

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I will argue: (1) that virtue-based ethics has lost its normative force because the moral philosophy on which it was based for so long is no longer intact in either general or professional ethics; (2) that, for a variety of reasons, the recovery of a common moral philosophy to sustain a normative theory of virtue ethics is too remote at the moment to be a viable possibility in general ethics; but (3) that virtue likely can be restored as a normative concept in the ethics of the health professions; and (4) that even in this limited realm, virtue cannot stand alone, but must be related to other ethical theories in a more comprehensive moral philosophy than currently exists.

This essay is divided into three parts: the first traces the origins, erosion, and present-day revival of the Classical-Medieval conception of virtue with particular emphasis on the reasons for its metamorphosis and decline; the second part provides a similar analysis of the concept of virtue in the ethics of medicine and the other health professions with an emphasis on the possibilities and requirements for its restoration as a normative concept; and the third part suggests how virtue-based ethics could be related to other major contemporary ethical theories in an integrated view of the four essential elements of the moral life, namely, agent, act, circumstance, and consequence.

ORIGIN, DECLINE, AND RESTORATION OF VIRTUE-BASED ETHICS

The Idea of Virtue Ethics

Virtue is the most ancient, durable, and ubiquitous concept in the history of ethical theory. This is so because one cannot completely separate the character of a moral agent from his or her acts, the nature of those acts, the circumstances under which they are performed, or their consequences. Virtue theories focus on the agent; on his or her intentions, dispositions, and motives; and on the kind of person the moral agent becomes, wishes to become, or ought to become as a result of his or her habitual disposition to act in certain ways. These phenomena are ineradicable elements of the moral life and any moral theory that ignores them fails to encompass the fullness and complexity of the challenge and struggle to be a good human being.

In a purely virtue-based ethic, the normative standard is the good person, the person upon whom one can rely habitually to be good and to do the good under all circumstances. This standard has been both the strength and the weakness of virtue-based ethics, the reason for its durability, but also for its fragility because of the circularity of its logic. The

challenge is to provide a normative force for virtue outside of the circular logic that holds the right and the good to be what the virtuous person takes them to be while defining the virtuous person as the one who is and does what is right and good.

Every culture has a notion of the virtuous person—i.e., a paradigm person, real or idealized, who sets the standards of noble conduct for a culture and whose character traits exemplify the kind of person others in that culture ought to be or to emulate. These paradigm persons are celebrated in the myths and stories, poetry and ritual, of Non-Western and Western cultures. The moral values and characteristics of these virtuous persons are given formal expression in the philosophy and theology of each era and culture. They are formalized in varying degrees in the works of Plato and Aristotle, the philosophy of Confucius (Cua 1978) and Lao Tse (Waley 1956; Yearly 1990), the Hindu concept of Dharma (Jhingran 1989), and the humanism of African tribal cultures (Wiredu 1992). Often the paradigm figures, such as Jesus, Buddha, or Confucius, antedated the community of values that would sustain them. In fact, frequently, the community of values and beliefs were framed on the model and through the person and personality of the paradigm virtuous person. The intricacies and the primacy of the mutual relationship between paradigm virtuous persons and communities of values have yet to be explored in depth.

The Classical-Medieval Conception—Origins

In the Western culture, the most pervasive and enduring concept of virtue, the one most formally and fully developed, is found in the thought of Plato and Aristotle, supplemented by the Stoics and Epicureans (Reale 1985; Rist 1980), and brought to full fruition by Thomas Aquinas. The fusion of those streams of thought became the Classical-Medieval synthesis that has shaped moral philosophy in the West for 2,500 years. Although it has gone through a variety of metamorphoses and decline over the centuries, the Classical-Medieval notion of virtue is re-emerging today among influential moral philosophers and is seeking its place among more recent normative ethical theories. This Classical-Medieval conception of virtue has also been the dominant one in the ethics of the health professions as professions. For this reason, it is the operative concept in this discussion of where to go "beyond virtue" in the wake of *After Virtue* (MacIntyre 1984).

The Classical-Medieval synthesis has been the subject of intense

scholarly exegesis for centuries. There is still much debate about various facets of the traditional notion of virtue—whether the virtues are one or many, how the doctrine of the mean (i.e., virtue as a mean state that lies between the extremes, the "vices," of excess and deficiency) applies to them, whether they can be in conflict, what "list" of virtues should prevail, and the like. An adequate discussion of these questions is beyond the confines of this essay, however. Rather, I have selected what I take to be the elements of the Clssical-Medieval synthesis that are most important for a resuscitation of virtue-based ethics in the health professions—i.e., the idea of virtue (1) as excellence in traits of character, (2) as a trait oriented to ends and purposes (that is to say, teleologically), (3) as an excellence of reason not emotion, (4) as centered on practical judgment, and (5) as learned by practice.

In and through the character of Socrates, Plato first advanced the idea of virtue as *areté*—i.e., excellence in the knowledge of the good, which made for a good and happy life. On this view, knowledge of the good disposes one to the good life and to happiness. The search for one's own good is "at the cornerstone of Socrates's moral philosophy" (Gomez-Lobo 1995, p. 108); the virtue one possesses makes one good. Vice is the result of ignorance of the good. Throughout his dialogues, Plato developed a list of the virtues: fortitude (*Laches*), temperance (*Charmides*), justice (*Republic*), and wisdom, which with self-restraint (*sophrosyne*), characterized the virtuous person. This list has survived as a list of the cardinal virtues—i.e., those that might subsume, or be the basis for, the other virtues. Socrates asks, but never satisfactorily answers, the questions that are still asked: Are the virtues one or many? How are they acquired? Can they be taught? (Plato 1961, *Meno* 70a)

Aristotle retains the idea of excellence and adds a strong emphasis on the *telos*, the orientation of virtues to the ends and purposes of human activity. He defines virtue as "...the state of character which makes a person good and makes that person to do his or her work well..." (*Nicomachean Ethics* (*NE*) 1106a22-24). Thus, for Aristotle, the teleological orientation of virtue is two-fold—the fulfillment of the natural end of human life, namely happiness, and also the attainment of the end of human work. Aristotle links being a good person with doing well whatever one does and with achieving, to the greatest extent possible, the end of any human activity whether it be the conduct of the whole of one's life or the conduct of a particular work related to the role or roles one plays in everyday life.

what virtue allows the agent to do

On this view, virtue is a character trait under rational control. Virtue is not a "habit" in the sense of being an unconscious reflex. Rather it is a *habitus*, a predictable disposition to choose the good whenever confronted with a choice (*NE* 1105a27-33). A virtuous person has knowledge of the good and chooses it for its own sake and from a firm character with regard to the passions (*NE* 1105b21-23). The virtuous person must not only know the good but *be* good (*NE* 1102b26, 1144b18). In contrast to Plato and Socrates, Aristotle takes account of emotion more clearly, but defines the virtuous person as one whose emotions are ordered by reason to the end of happiness.

Virtue is also practical in its orientation. For this reason, Aristotle's central virtue is *phronesis* or practical wisdom. Moral agents must consider what is appropriate to the occasion: "Virtue determines the end; practical wisdom makes us do what is conducive to the end" (*NE* 1145a5-6). Thus, *phronesis* is the virtue that enables one to deliberate well in making moral judgments and to choose the means most suited to the end of the activity in which one is engaged. Practical wisdom is a "...true and reasoned capacity to act with regard to the things that are good or bad for men" (*NE* 1140b5). *Phronesis* fuses the intellectual virtues, which have truth as their end—e.g., science, art, intuitive wisdom—with the moral virtues, which have the good as their end. The good person is the *phronimos*, the person of practical wisdom; the virtuous act is the act as it would be chosen by the *phronimos*.

Aristotle criticizes Plato's ethics as too general (*Politics* 1260a25) and unmindful of the emotions (*Magna Moralia* 1182a20). In keeping with his emphasis on the practical, Aristotle teaches that virtue is, itself, learned by practice. Thus, he answers in the affirmative one of the questions Meno put to Socrates (*Meno* 70a). By repeatedly acting in conformity with the ends of human life, as the man of practical wisdom would act, a person becomes habitually disposed to act virtuously. One can then depend on the virtuous person to act well in all circumstances.

Aristotle recognizes that certain things ought never be done—e.g., adultery, murder, and theft—and certain dispositions ought never be adopted—e.g., spite and envy (*NE* 1107a10-11). With the exception of those acts and dispositions that do not allow of a mean, Aristotle does not lay down rules, duties, or principles. We must be "content" with the "...truth roughly and in outline..." (*NE* 1094b20). Instead, in general, "...excellence is a state of choice lying in a mean related to us and in the way in which the man of practical wisdom would determine it" (*NE*

1107a1-3). Aristotle's mean is not just a mean between extremes; it is also the right amount for a given individual, determined not subjectively, but rationally as the man of practical wisdom would determine it (Prior 1991, pp. 159-60). The morally good is what the virtuous person does; the virtuous person is one who does what is morally good.

Thomas Aquinas (1963), in his great study of Christian theology and Greek philosophy, develops a virtue-based ethics that begins with the same elements as Aristotle's (*Summa Theologiae* (*ST*) II-II, 108: 2 and *ST* I-II, 119: 8-15). He defines virtue very much as Aristotle does: "It belongs to human virtue to make a man and his work according to reason" (*ST* II-II, 108: 2). He posits truth as the end of the natural intellectual virtues and the good of humans as the end of the natural moral virtues. However, drawing on Christian theology, Aquinas adds the theological virtues of faith, hope, and charity. These virtues dispose humans to attain their supernatural end—union with God in the beatific vision. The infused virtues orient humans to their ultimate end of union with God: faith orients to that end, hope enables the Christian to stay the course, and charity attaches the Christian to God (*ST* I-II, 119: 8-15). Of the theological virtues, charity or love is the ordering virtue (Pinckaers 1985).

For Aquinas, as for Aristotle, practical wisdom is a central virtue. Prudence is analogous to *phronesis*. Its function is the actualization of the other virtues in attainment of the goals of human life (Pieper 1966, p. 33). Not only does prudence link the intellectual and the moral virtues, as it does in Aristotle, but it also links those virtues to the theological virtues. Prudence is a "*recta ration agibilium*," a right way of acting according to reason (Maritain 1949, p. 116). It disposes persons to choose means that most closely fit the *telos* of an act. Prudence is the virtue that sorts out the other virtues when they might be in conflict and provides practical judgment and discernment in complex circumstances thereby giving its possessor the capacity to select the means that will most closely approximate the end of a particular human activity.

The Classical-Medieval Conception—Decline

Both the Classical and the Medieval Christian conceptions of virtue were based on a clear moral epistemology and metaphysics. They were rooted in the conviction that there existed an objective moral order and a philosophy of human nature ascertainable by human reason, which, in turn, defined the *telos* for human activity. The virtues were traits that

habitually disposed humans to act in accord with the ends of human nature—i.e., fulfillment in natural happiness for Socrates, Plato, and Aristotle and supernatural happiness in union with God for Aquinas. On this view, the virtues have normative force not because they are agreeable or admired but because they accord well with, and predispose to, the ends, the purposes, and the good of human beings as defined by an underlying metaphysics.

In the post-Medieval and post-Enlightenment periods up to the present, these metaphysical foundations for virtue ethics were seriously eroded by the confluence of a variety of forces. The possibility of a metaphysical definition of human nature or the good, the epistemological possibility of moral knowledge, and the possibility of a philosophical anthropology were all subjected to skepticism and denial. Beginning in the Enlightenment, theology, religious authority, and even reason were challenged as sources of morality. Aristotelian philosophy and the methods of scholasticism were especially suspect in science and theology. Hobbes and Locke replaced the Classical and Medieval philosophies of human nature with "realism" about the dubious nature of human motives and conduct; Hutcheson and Hume advanced moral psychology to counter the over-rationalization of Classical and Medieval ethics (Hume 1975). Virtues were replaced by a variety of competing concepts: rights for Locke, duty for Kant, moral sentiment for Hume and Smith, and consequences and utility for Bentham and Mill (Sidgwick 1988; Becker and Becker 1992).

From its inception, the concept of virtue had strong opponents who ridiculed it as a basis for morality. Glaucon, Ademantus, and, later, Thrasymachus, in Plato's *Republic* and Callicles in the *Gorgias* attacked the idea of virtue as unrealistic and vulnerable to submersion by power and self-interest. Later philosophers reinforced this anti-virtue bias. *Machiavelli (1970)* maintained that the virtuous person was doomed in a world in which others were not virtuous; Mandeville (1962) argued that vice was necessary for the survival of the economy and society; and Nietzsche thought virtue, especially the Christian virtues, was a mark of weakness unbecoming the Superman (Nietzsche 1924, 1967). More recently, Ayn Rand (1964), voicing the implicit ethics of the marketplace, condemned the traditional conception of virtue as inimical to the ethos of success.

The concept of virtue survived these assaults in a revised form. As the philosophical foundations of the Classical-Medieval synthesis eroded,

virtue was redefined in terms of the emergent newer schools of philosophy. For present purposes, only a few of the multitudinous revisions need be mentioned as examples: Hume (1975, p. 211) sees virtue as "...a quality of mind agreeable to, or approved by, everyone who considers or contemplates it." For Kant (1986, Ak 394-396), virtue is the coincidence of the rational will with every duty firmly settled in the character. For Bentham (1969), as one might expect of a utilitarian, a virtue is a trait that disposes its possessor to increase the quantity of happiness. Many other definitions followed, each framed in terms of an underlying philosophical system. The result was the eclipse of virtue as a normative concept by intuition, moral psychology, maxims, rules, and principles.

In the twentieth century, the revolution against a metaphysical or theological foundation for ethics came to full fruition. The history of this revolution is complicated beyond the scope of this paper. Suffice it to say that ethics turned to meta-analysis, to the dissection of the language of moral discourse, to the intuitive grasp of the good or of *prima facie* principles discoverable by morally mature persons, or to a variety of alternatives to principles, such as, casuistry, hermeneutics, feminist psychology, care theory, or narrative. At present, these theories and a revitalized virtue-based ethics are in competition with each other. They share a repudiation of the philosophical and theological groundings that have traditionally given virtue-based ethics its normative thrust. Each of the theories holds one or another of the shards of the Classical-Medieval synthesis—i.e., of virtue-based ethics—without the philosophical cement to repair the damage done.

how new theories edge out virtue based theories

Virtue-Based Ethics—The Revival

Despite the convolutions in the concept of virtue wrought by a succession of philosophical systems, the ideas of virtue and the virtuous person were never erased. Ethicists continued to confront the question of character of the agent. Principles, rules, maxims, intuitions, language analysis, and technical skill in solving moral puzzles did not encompass the full complexity of the moral life. The central nature of the character of the moral agent could not totally be ignored (Kuperman 1991). As a result, several decades ago, a number of contemporary moral philosophers began to revive the idea of virtue and to seek a place for it in ethical theory (Foot 1978; Frankena 1982; French, Uehling, and Wettstein 1988; Hauerwas 1981; MacIntyre 1984, 1990).

The philosophers who were most successful in doing so found it nec-

essary first to revive, or at least to revise, the philosophical or theological substratum on which classical virtue theory had been built—either in Plato, Aristotle, Aquinas, or their commentators. It remains to be seen how successful these attempts to restore virtue will be in general ethical theory given the post-Modernist doubts about the utility of philosophical ethics or even of philosophy itself—especially in its current anti-foundationalist mind set (Baynes, Bohman, and McCarthy 1987; Rockmore and Singer 1992). It seems unlikely that a robust virtue ethics can be reconstructed since the probability of agreement on a conception of the good or the *telos* of human life is remote indeed. Such agreement is required, however, for any normative theory of virtue. Lacking it, we are left with such conflicting definitions of virtue as "...a corrective to the tendency to act against the good" (Foot 1978, p. 8), or any trait that ameliorates the human condition (Warnock 1971) or enhances evolutionary adaptation (Casey 1990; Wilson 1980).

MacIntyre has most successfully built on the Aristotelian notion of virtue and reformulated it in more contemporary terms, taking into account the erosion of the tradition and the moral consensus that gave the classical doctrine its normative strength. MacIntyre (1984) builds his definition on three elements; he regards virtues as dispositions or acquired qualities that are: (1) necessary to achieve the good internal to practices,[1] (2) necessary to sustain communities in which individuals can seek a higher good as the good of their own lives, and (3) necessary to sustain traditions that provide necessary historical contexts for individual lives. Virtue, thus, is a character trait necessary to achievement of a good—a perfected excellence (MacIntyre 1988, p. 74). In this, MacIntyre adopts the teleological thrust of the Aristotelian definition of virtue and adds to it the sustaining force of a historical community of values.

This is not the place to evaluate MacIntyre's reformulation. However, he does make a genuine attempt to recapture some of the Aristotelian notion of virtue. MacIntyre (1990) clearly recognizes the difficulties that his reformulation faces in the absence of a shared notion of the good or a community of values to sustain it. In a more Platonic vein, Iris Murdoch (1992, pp. 482-84) also recognizes the need for and the difficulty of recovering a conception of the good as a foundation of moral life and of the virtues. Murdoch intimates strongly that the good has to confront religious reality as well, although she does not locate the good in a formalized religious belief system. In this, she counts virtue as

"...the most evident bridge between morality and religion" (Murdoch 1992, p. 481).

In any case, the improbability of any recovery of the philosophical or theological substructures of virtue compounds the difficulties of a contemporary revival so far as general ethical theory is concerned. This is amply evident in the incommensurability of premises and methodologies characteristic of general theories of ethics. However, these impediments are less formidable in professional ethics, particularly in medicine and the other health professions. It is here that genuine possibilities for a restoration and reformulation of virtue ethics exist.

Difficulties Inherent in the Classical-Medieval Synthesis

Before turning to the possibility of restoring virtue ethics in the health professions, it may be well to examine the inherent difficulties of any virtue-based ethics as a normative theory. If virtue is to be restored to normative status, these difficulties must be acknowledged and addressed.

First is the circularity of justification to which I have already alluded, namely, that the good is that which the virtuous person does and the virtuous person is the person who does what is good for humans. Some grounding for virtue outside of this circular logic is necessary if the redundancy of this logic is to be avoided. Otherwise, virtue can become so intuitive and subjective as to be meaningless. What is virtue to one person's community is vice to another's. What some find "agreeable"—to use Hume's term—others find disagreeable with equal intensity.

In the Classical and Medieval construals of virtue, its grounding was in the ends and purposes derived from an underlying philosophical anthropology based in natural law. Within this anthropology, virtues could be defined, rejected, and even ordered with respect to one another. Their normative power arose not from their simple, intuitive affirmation as virtues but from the congruence of virtues with something more fundamental to which virtues and virtuous persons themselves conformed. This grounding is the antidote to the multiplicity of definitions and the proliferation of lists of the virtues—lists that sometimes grow to ridiculous proportions and include every imaginable agreeable trait from the most profound to the most trivial. Instrumental, moral, intellectual, and spiritual virtues become intermingled with "values," beliefs, preferences, tastes, and the like. Any characteristic agreeable to

someone can be touted as a virtue.[2]

A second difficulty in virtue-based ethics is the paucity of the definitive action guidelines that give principles, rules, and maxims their force—at least in the abstract. A virtue-based ethics depends upon the grasp by the virtuous person of the good for humans in such a reliable way that, no matter what the act or the circumstances may be, that person will know how to attain the good. Such an open-ended guide to moral choice is sustainable only if there is, in fact, some agreement on the good for humans. A shared notion of the good gave focus to Aristotle's *Nicomachean Ethics* and *Eudemian Ethics*, to the Platonic dialogues, and to Aquinas's *Summa Theologiae*. But it is disagreement on the good that divides modern and contemporary ethical and metaphysical theory. So much is this the case that many deem futile the pursuit of a definition of the good beyond intuition (Moore 1903). With many goods being equally defensible, there will be many interchangeable virtues and vices. The contemporary inclination of philosophy is to abandon the quest for the good, to define it by intuitive grasp only, or to deny its existence altogether.

Third is the difficulty of supererogation. The classical insistence on the virtues as excellences seems to demand too much. In a legalistically shaped society—one that, in addition, emphasizes individual choices and life-styles—even the narrow idea of role-related responsibilities and duties is challenged. The only duty is not to infringe on the liberty of others. Everything else is beyond duty. In such a setting, virtue in the classical sense is too much to ask of individuals or communities and institutions.

Some would argue that the possession of virtues and the accompanying disposition to excellence is entirely fortuitous, the product of genetics, environment, or luck (Casey 1990; Wilson 1980). How, in justice, can we demand virtue from those who do not possess it innately? How do we attribute virtuous behavior to those who are genetically disposed to it? Is it not unfair to impose a demand for supererogation on those who are congenitally indisposed to even ordinary duties? Without the classical notion of virtue as an "excellence" consciously and rationally practiced, it may be difficult to see virtue as "virtuous."

Any viable normative account of virtue-based ethics must somehow engage these difficulties and objections. As I have already suggested, in our times at least, this is so formidable a task in general ethics that it

likely is destined for failure. However, as I now hope to show, there is a reasonable possibility of satisfying the requirements for a normative virtue-based ethics in the more limited case of professional ethics.

VIRTUE-BASED ETHICS IN MEDICINE—HISTORY AND REVIVAL

Origins and Metamorphosis

The history of the concept of virtue in medical ethics follows in general outline the history of the origin and metamorphosis of virtue in general ethics that I have described. However, in medicine, virtue ethics resisted erosion for a longer period of time, and change, when it did come, did so over a period of twenty-five years, rather than the five or six centuries that it took in general ethics.

Therefore, in medical ethics, as in general ethics, virtue was the dominant normative theory for a long period of time. It is the basis for the Hippocratic Oath and the deontological books of the Hippocratic Corpus. In the Medieval world, as in the present, the Hippocratic ethic was joined with the ethics of the major world religions. For centuries, that ethic united physicians across cultural and national boundaries in a community of moral values based in the virtues of benevolence, respect for human life, and the vulnerability of the sick.

A quarter of a century ago, the dominance of virtue in medical ethics began to diminish for three reasons: First was the introduction of principle-based ethics (Beauchamp and Childress 1989), which appealed to health professionals as being more definitive than virtue because of its concreteness and applicability to clinical decisions. Second, socio-political change toward participatory democracy, greater public education, distrust of authority, and the character failings of some physicians focused public attention on autonomy-based, contractual relationships rather than trust-based, covenantal ones. Third, and importantly, the religious and philosophical consensus that undergirded professional ethics, at least in the West, was challenged and weakened (Pellegrino 1986).

Today, as a result, medical professional ethics is gradually being deconstructed as its conceptual substratum is progressively challenged. The Hippocratic Oath, the backbone of traditional medical professional ethics, is in danger of complete dissolution. It is already defunct in the minds of some very creditable ethicists (Veatch 1984)—done-in by the societal pressures to substitute autonomy or social justice for beneficence and to relax the proscriptions against abortion, euthanasia, assisted sui-

cide, breaches of confidentiality, and sexual relations with patients. In any gathering today, it would be difficult to find a commonly accepted set of precepts or virtues that should characterize the "good" physician (Pellegrino 1988).

These changes are occurring in the domain of *professional* ethics—i.e., the domain of duties, obligations, and virtues entailed in the health professional's roles as a healer and as a participant in a special kind of relationship with a patient. Professional ethics centers on the generic obligations of the healing relationship, those common to physicians as physicians, nurses as nurses, and so on. Professional ethics is the realm of the ethics of the physician- or nurse-patient relationship. This realm is a domain distinct from the growing body of other ethical issues commonly subsumed under the rubric of "bioethics"—i.e., the issues of withholding or withdrawing life-support, euthanasia and assisted suicide, embryo research, organ and tissue transplantation, managed care, and the like; the whole panorama of new issues growing out of medical technological advances.

These are the "content" questions of bioethics—the questions that have become so problematic as a result of the loss of consensus about the meanings, purposes, and value of human life. Given the pluralism, the relativism, and the privatization of morals, there seems to be little hope for agreement on such questions at the moment. Recovery of a normative role for virtue in such circumstances without agreement on the philosophical foundations for the virtues is quite remote. To recognize this fact is not to admit that moral truth is impossible or that virtue is no longer a viable concept, but only to suggest that a first, and more practical, step is to confine consideration of a restoration of virtue-based ethics to professional ethics. Whether this opening later will extend into the realm of specific moral choices that are of such consuming interest in bioethics is unforeseeable at this time.

I will now address the reasons that professional ethics is a promising prospect for virtue ethics; what the requirements for a viable, normative ethics might be; and how those requirements might be satisfied.

The Restoration of Virtue in Professional Ethics

The Opportunity

There are several good reasons to suppose that a return to virtue is a reasonable probability in professional ethics. Paradoxically, some of the reasons arise from the deficiencies now being perceived in the dominant

school of principle-based moral guidelines; others stem from the more limited scope of professional ethics within the larger field of bioethics.

First is the growing disquiet in the last decade with some of the limitations of principle-based ethics. Principles are thought to be too abstract, too removed from the contextual and experiential complexity of clinical decision making, and too conducive to an overly rationalistic, quasi-legalistic ethics that over-emphasizes quandaries and stifles compassion and moral creativity (Clouser and Gert 1990; Carse 1991).

Second is the criticism that *prima facie* principles need to be grounded in some more fundamental philosophical system to give them the normative weight they must carry. Such a foundation is needed to resolve conflict between and among principles in more than a pragmatic and functional way—perhaps even to give them a lexical ordering in specific situations, if not generally.

Third is the persistent appreciation that moral agents—i.e., persons acting—cannot be left out of moral judgments. This fact has hovered over general and medical ethics even in the period of its most radical change. The moral life is a life peculiar to the human species. The way in which principles, rules, caring, hermeneutics, casuistry, or any other alternative theory of ethics is conducted will depend on the kind of persons carrying out the moral acts and their analyses. Intention, moral psychology, and the "story" of the agent's life cannot be separated from the agent's moral behavior. To avoid looking at virtue and intentions and to assume that the only justification for moral acts lies in principles are thought by many to favor the right over the good.

These shortcomings in principle-based ethics are reinforced on the positive side by the nature of professional ethics. Unlike general ethics, professional ethics offers the possibility of some agreement on a *telos*—i.e., an end and a good. In a healing relationship between a health care professional and a patient, most would agree that the primary end must be the good of the patient. The healing relationship, itself, provides a phenomenological grounding for professional ethics that applies to all healers by virtue of the kind of activity that healing entails. In general ethics, on the other hand, at least at present, the analogous possibility for agreement on something so fundamental as the *telos*, end, or good of human life is so remote as to be practically unattainable.

The Necessary Ingredients

At a minimum, any normative theory of the ethics of the healing relationship based in virtue will require the following: (1) a theory of medi-

cine to define the *telos*, the good of medicine as an activity; (2) a definition of virtue in terms of that theory; and (3) a set of virtues entailed by the theory to characterize the "good" health professional.

A theory of medicine. David Thomasma and I (1981, 1988) have outlined a theory of medicine in some detail elsewhere. For the purposes of this essay, I will simply summarize that theory from which I will draw the *telos* and, thus, the virtues of the good physician or nurse (Pellegrino and Thomasma 1993). The theory is grounded in three phenomena of the healing relationship, in the realities and actualities of the clinical encounter that establish medicine and nursing as particular kinds of human activity (Pellegrino 1994): the fact of illness, the act of profession, and the act of medicine (healing).

The fact of illness. Persons become *patients* when they acknowledge that they are sufficiently concerned over a physical or psychological symptom to believe they need help. In this state, to varying degrees, they are anxious, dependent, in pain, disabled, and extremely vulnerable and exploitable. They are no longer free to pursue the things they want out of life without impediment. If they are to be helped, healed, and cared for, they must seek out a health professional, someone who possesses the knowledge to accomplish these ends for, and with, them.

The act of profession. To move from a state of health to a state of illness is an experiential and existential change in the way we perceive our humanity. In that vulnerable state of illness, the physician or nurse asks, "How may I help you?" Implicit in the question is the promise that the health professional possesses the knowledge needed to help and to heal and intends to use it in the interests of the patient and not at the expense of the patient's vulnerability. This "act of profession" is an act of implicit promise making that establishes a covenant of trust at the physician's or nurse's voluntary instigation. This self-imposed trust covenant imposes obligations on the professional from the moment it is made.

The act of healing. The promise made to the dependent patient directs the knowledge, techniques, and personal commitment of the physician or nurse to the *telos* of the relationship—helping and healing. The diagnostic, prognostic, and therapeutic acts—which are manipulative, judgmental, cognitive, and so on—must be directed to what is necessary to heal and to help *this* patient, to a technically correct and morally good decision and action. This is the immediate *telos* of the clinical encounter, which is, in turn, part of the ultimate *telos* of health care—the cultivation and restoration of health and the containment or cure of disease. To

be sure, healing may occur outside of medicine and the health professions, but that which is specific to the health professions is the attainment of the *telos* of healing through the science and the art of medicine—those things specific to medicine as a particular kind of human activity.

A Definition of Professional Virtue

The second ingredient of a virtue-based normative theory of medical ethics is a definition of virtue in terms of the *telos* of the clinical encounter. This encounter defines medicine as the kind of activity it is. A definition suited to professional activity would draw on the elements of virtue as defined by Aristotle and its adaptation to practices as defined by MacIntyre.

Drawing on these two sources, I define a virtue as a trait of character that disposes its possessor habitually to excellence of intent and performance with respect to the *telos* specific to a human activity. Virtue gives to reason the power to discern and to will the motivation asymptotically to accomplish a moral end with perfection. For any profession, there will be a specific activity that, if executed well, makes the professional good or virtuous. Healing is the activity specific to nursing and medicine. Those dispositions that impart the capacity to heal well are the virtues of medicine, nursing, dentistry, and the like. They are the virtues "internal"—in MacIntyre's (1981, p. 187) sense—to the practice. Possession of these internal virtues defines the good nurse or physician.

A List of Virtues

The third ingredient of a virtue-based normative theory of medical ethics is a list of virtues that will define the "good" physician, nurse, or other health professional. These are the virtues entailed by the phenomena of the relationship and the *telos* of medicine. They are the virtues essential to achieving the ends of medicine optimally and without which those ends would be frustrated or attained in less than optimal fashion.

Lists of virtues are notoriously difficult to compose. The following list is not meant to be inclusive of all the virtues necessary to healing. Rather, the virtues included are those most essential to the healing purposes of the clinical encounter. In that sense, they are "entailed" by the end of the healing relationship, that is, they are required if the end is to be attained. The virtues are not listed in order of preference. They reinforce each

other so closely that to compromise one is to compromise the others. A lexical order among them would be difficult to defend.

Pellegrino list seven virtues

Fidelity to Trust and Promise

This virtue is entailed by the ineradicability of trust in the patient-nurse or patient-physician relationship, the invitation of the professional to trust when the relationship is initiated, the importance of trust to healing, and the fact that, ultimately, the patient has no choice but to trust the professional.

Benevolence

This virtue intends the good of the patient. It is a *sine qua non* since the patient obviously seeks to be helped not harmed. Intending every act to be in the patient's interest is the gold standard of medical ethics.

Effacement of Self-Interest

Given the exploitability and vulnerability of patients, a certain degree of self-effacement is entailed since without it the patient can become merely a means to advance the physician's power, prestige, profit, or pleasure. In these days of managed and for-profit care, the need for effacement of self-interest is urgent if the patient is to be protected against exploitation.

Compassion and Caring

If the patient is to be healed in the fullest sense, the physician or nurse must have compassion—i.e., the health professional must be able to feel something of the patient's experience of the predicament of illness. Such feeling is essential to adjusting the treatment to the particularities of *this* patient's life story, time of life, and so forth. Compassion is the prelude to caring—to concern, empathy, and consideration for the patient's plight. On this view, caring in its several meanings (cf. Pellegrino 1985) is more in the realm of virtue ethics than being an ethical theory of its own.

Intellectual Honesty

By virtue of the trust that health professionals enjoy and the power of knowledge and skill they exercise, physicians and nurses can be agents of great harm as well as great good. Acknowledging when one does not know something and being humble enough to admit ignorance is a virtue of healing. Knowing when to say "I do not know" is a virtue counselled by sources as different as the Babylonian Talmud and Galileo.

Justice

In the healing relationship *per se*, the virtue of commutative justice is implicit throughout. Commutative justice dictates that in interpersonal relationships what is owed to each is rendered to each and equals are treated equally. Taken as a principle, justice is blindfolded and applied strictly. But taking justice as a virtue in the healing relationship requires removing the blindfold and adjusting what is owed to the specific needs of the patient, even if those needs do not fit the definition of what is strictly owed.

Furthermore, when the physician is bound by a covenant of trust to *this* patient, distributive justice—what is owed to others in a more distant relationship to the physician—takes a lesser place. After all, the covenant, the promise to help, is made to an identifiable sick person, not to society at large nor to the managed care organization, nor even to other patients with similar needs. As I have argued elsewhere, this does not excuse the physician from societal justice outside of the covenant with a given patient here and now (Pellegrino 1986).

Prudence

Practical wisdom, the virtue of deliberation and discernment, was central to Aristotle's virtue theory as *phronesis* and to Aquinas's as prudence. It is equally central to any theory of virtue in the health professions since any clinical decision of note requires prudent weighing of the alternatives in situations of uncertainty and stress. Knowing how to unscramble apparent conflicts among the virtues, understanding their relationships to one another, and selecting the means by which to approximate most closely the *telos* of any particular healing relationship are essential tasks for the virtue of prudence in the health professions.

At a minimum, the foregoing seven virtues are entailed by the nature of the physician- or nurse-patient encounter. They can be supplemented by other virtues, but most others will be variants of these basic seven. One might argue that even the seven virtues could be reduced to benevolence, fidelity to trust, and prudence. Such a reduction begins to touch on Meno's question to Socrates about whether the virtues are one or many. In the end, however, it is less important to answer this question than to agree on a notion of the good for humans engaged in a healing relationship and on some list of virtues that are required to achieve the good within a community of healers (the profession) who can sustain that conception of the good.

VIRTUE CANNOT STAND ALONE

The schema of virtues for the health profession that I have outlined can give normative force to professional virtues, but, by itself, it is insufficient to constitute a comprehensive normative theory of ethics. The inherent difficulties of virtue as a normative concept are not, thereby, fully resolved. We may have gained insight into the kind of person the moral agent is, or is striving to become. We may also have given the virtues—at least those pertinent to being a good professional—the philosophical foundation they require if they are to have normative form. Still needed, however, is a description of the way in which the ethics of the agent that is expressed in a virtue-based ethics relates to the ethics of the other elements of a moral event.

Granting the undeniable fact of moral agency, no matter what theory of ethics one follows, it remains to give an account of the nature of the act, the circumstances under which it takes place, and the consequences of the act. These are realities of "moral events," i.e., specific instances of moral conduct essential to moral judgment and justification. In the act, the circumstances, and the consequences lie those additional contextual complexities that the present upsurge of alternative theories of ethics seeks to encompass. Each alternative adds to our understanding of some important facet of moral judgment. Each illuminates the other theories as well. Like virtue theory, each is necessary, but not sufficient, as a normative theory.

Figure 1 depicts schematically how some families of ethical theories focus on different but interrelated elements in any moral event:

Figure 1. THE MORAL EVENT

	Agent	Act	Circumstance	Consequence
Theories	virtue	deontology	particularizing theories	teleology
Foci	character intention desire choice will accountability caring	right good duty rule maxim	caring for *this* person or group in this place, time, etc. narrative, culture, uniqueness of the person experience "situation ethics" casuistry	outcomes harms/goods pain/pleasure utility calculus

Virtue theories focus on the agent and his or her character as it is expressed in, and influenced by, intention, desire, choice, strength of will, and caring (in the sense of feeling for others). Accountability, innocence, and guilt are resultants of the interplay of these factors in the character of the agent. Many of these foci are in the realm of moral psychology. As such, they can impart understanding, but they are not *per se* normative. Moral psychology helps us to understand how and why a person might be the kind of person he or she *is*, but not the kind of person he or she *ought* to be.

Deontological theories focus on the act, itself, on whether it is right and good—in keeping with some moral standard, i.e., a principle, rule, maxim, or duty, that is, itself, derived from an underlying moral philosophy. The agent is judged by whether, and to what degree, his or her moral conduct is in accord with a universalizable norm from which specific actions, rules, or guidelines are derived. The standard may be utility, beneficence, justice, or Kant's Categorical Imperative. Deontological theories have a normative force and a specificity not shared by concepts like virtue or caring. The specificity of principles is abstract, however. With deontological theories, there is always the difficulty of closing the gap between general moral rules and their application in particular moral events.

A whole family of theories are "particularizing" in the sense that they focus upon and emphasize the moral situation, the circumstances and the historical, cultural, and personal features that make each moral event unique. These are precisely the details on the other side of the gap that must be crossed in the application of principles or virtues. Some recent examples are: ethical theories based on narrative and story, lived experience, historico-cultural or genetic predispositions, caring for particular persons, casuistry, and hermeneutics. This family of theories fills in the rich detail of a moral event not capturable by virtue-based or deontological theories. Particularizing theories, like theories of moral psychology, are most valid for explanatory and heuristic purposes, but they are not *per se* normative. All particularizing theories suffer from being too closely enmeshed in concrete details to be normative—unless one is willing to accept situation ethics, and its conceptual liabilities, as a normative theory.

Finally, acts have consequences, and those consequences have moral force. If they produce harm, or more harm than good, they may be judged using a moral calculus of varying degrees of precision. The diffi-

culties of such a calculus notwithstanding, consequences are ineradicable elements in any comprehensive normative theory. Like the other theories, consequences are linked to the circumstances and the nature of the acts in question. They are more or less independent of intentions—unless the character-damaging effects of immoral acts on the agent are taken into account as consequences.

In any case, what is evident is that full accounts of the moral life, particularly as it regards judgments of accountability and justification, require an integrated assessment of the four elements of a moral event—i.e., the agent, the act, the circumstance, and the consequence—in relation to each other. Today's challenge is not how to demonstrate the superiority of one normative theory over the other, but rather how to relate each to the other in a matrix that does justice to each and assigns to each its proper normative force. The necessity of such an effort becomes clearer when one realizes that there are very few moralists who consistently use only one theory in their deliberations. Rather, it is a question of primacy of one theory over the others and of when one theory may be used in preference to another. If, instead of this primacy, attention is focused on the four elements of moral events, the challenge becomes one of the interrelationships between a variety of theories, each illuminating important facets of moral judgment.

I am not suggesting a feeble eclecticism, a cafeteria-style ethics, that would add a spoonful of virtue here, a principle there, and a dash of consequence in another place. Nor do I suggest a formless syncretism based in egregious compromises for the sake of a unity that enervates conflicting theories. Rather, the strength of each theory must be preserved, drawn upon, and placed in dynamic equilibrium with the others in order to accommodate the intricacy, variety, and particularity of human moral acts.

Here, as in the restoration of the normative force of virtue-based ethics, the possibility for some success is greater in the limited field of professional ethics, in which the good of the healing relationship is more easily definable than in general philosophy or in bioethics, where the nature of the good for humans is much more difficult to grasp.

CONCLUSION

The conceptual perambulations of moral philosophy over the centuries notwithstanding, virtue-based ethics continues to hover over ethical theory. This is because, being a human endeavor, ethics cannot con-

veniently ignore the moral agent. But, if virtue ethics is to have normative force, it must break out of the circular logic that defines virtue as that which the virtuous person does and the virtuous person as one who acts virtuously. To break this circle, the concept of virtue must be defined in terms of some good, some *telos*, which the agent intends and acts to attain.

In the past, the *telos* was the good for human beings as derived from a philosophy of human nature. That *telos* and its foundation gave moral force to the virtues because the virtues disposed a person to the good. In modern times, the philosophical notion of the good, and, consequently, of the virtues, has been seriously weakened. For a variety of reasons, there is little likelihood of recovering a common notion of the good, of the virtues, or of human nature. As a result, the recovery of normative force for virtue in general ethics is remote.

In professional ethics, however, the possibility is more realistic. Here, a definition of virtue, a theory of healing, and a list of virtues related to both are more clearly conceivable. But, even in this case, virtue-based ethics cannot stand by itself as a normative theory. It needs to be conceptually related to other ethical theories in a comprehensive, integrated moral philosophy of the health professions. The elaboration of such a moral philosophy is a daunting but necessary task for the philosophy and ethics of the health professions.

NOTES

1. 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 1984, p. 187).
2. Pincoffs (1986, p. 85) expands Hume's notion of agreeableness into a bewildering list of likeable qualities that he considers virtuous.

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