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Virtue ethics: in pursuit of excellence

Ética das virtudes: em busca da excelência

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ABSTRACT: Virtue ethics is the oldest model of moral philosophy, but since the Renaissance it has been relegated to second place with the emergence of the Kantian duty-based ethics and the consequentialism of Bentham and Mill. In the context of healthcare, ethical theories centered on virtue and character continued to be prevalent until the 1970s, when bioethics emerged as a new area of knowledge that seeks to reflect on the ethical implications resulting from scientific and technological advances on human and animal life, and on the environment. There was a paradigm shift in healthcare ethics, from a model based on virtue and on the inviolability of human life, expressed in the Hippocratic Oath, to a model based on the autonomy and quality of life of the patient, to which contributed the principlism of Beauchamp and Childress and the growing influence of utilitarianism in the ethics committees. In recent years, there has been a renewed interest on virtue-based ethics due to the contribution of thinkers such as Elizabeth Anscombe, Alasdair MacIntyre, and Edmund D. Pellegrino. A review on virtue ethics was carried out from the works of Edmund D. Pellegrino and David C. Thomasma, pioneers of bioethics and the main promoters of virtue ethics in clinical practice, as well as after research on the subject in the NCBI/PubMed (National Center for Biotechnology Information) and SciELO (Scientific Electronic Library Online) databases. After a presentation of the history of the philosophical concept of virtue and the most representative aspects of virtue ethics, eight virtues particularly relevant to clinical practice are emphasized: fidelity to promise, compassion, prudence, justice, courage, moderation, integrity, and altruism. These and other virtues are, in our opinion, essential for a more humane healthcare that considers the patient's good and will contribute to counterbalance the hegemony of principlism and ethical theories that devalue the central role of the agent in the current bioethical debate.

Keywords: Virtues; Medical ethics; Ethical theory; Bioethics.

RESUMO: A teoria ética das virtudes é o modelo mais antigo de filosofia moral, mas a partir do Renascimento foi relegada para segundo plano com o surgimento da ética kantiana do dever e do consequencialismo de Bentham e Mill. No âmbito da saúde, as teorias éticas centradas na virtude e no caráter continuaram a ser preponderantes até aos anos 70 do século passado, quando surgiu a bioética como uma nova área do saber, que procura refletir sobre as implicações éticas resultantes dos progressos científicos e tecnológicos na vida humana e animal, e no ambiente. Assistiu-se a uma mudança de paradigma na ética dos cuidados de saúde, de um modelo baseado na virtude e na inviolabilidade da vida humana, expresso no Juramento de Hipócrates, para um modelo cimentado na autonomia e qualidade de vida do paciente, para o que contribuiu a proposta da metodologia principialista de Beauchamp e Childress e da crescente influência do utilitarismo nas comissões de ética. Nos últimos anos, tem havido um interesse renovado pelas teorias éticas da virtude devido ao contributo de pensadores como Elizabeth Anscombe, Alasdair MacIntyre e Edmund D. Pellegrino. Foi realizada uma revisão sobre a teoria ética das virtudes a partir das obras de Edmund D. Pellegrino e David C. Thomasma, pioneiros da bioética e dos principais promotores da ética das virtudes na prática clínica, bem como após pesquisa do tema nas bases de dados NCBI/PubMed (National Center for Biotechnology Information) e SciELO (Scientific Electronic Library Online). Após uma apresentação da história do conceito filosófico de virtude e dos aspetos mais representativos da teoria ética das virtudes, são destacadas oito virtudes particularmente relevantes para a atividade clínica: a fidelidade à promessa, a compaixão, a prudência, a justiça, a coragem, a moderação, a integridade e o altruísmo. Estas e outras virtudes são, em nossa opinião, essenciais para uma prática médica mais humanizada que tenha em conta o bem do paciente, e contribuirão também para contrabalançar a hegemonia do principialismo e de teorias éticas que desvalorizem o papel central do agente no debate bioético atual.

Palavras-chave: Virtudes; Ética médica; Teoria ética; Bioética.

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INTRODUCTION

Virtue ethics is the oldest model of moral philosophy[1]. In the golden period of Greek antiquity, Plato's dialogues and the works of Aristotle introduced and developed the concept of virtue as the excellence of a person's character, which had an enormous influence on Western thought until our days.

Duty-based ethics and utilitarianism, more widespread and influential in contemporary moral philosophy and bioethics, focus the reflection on the action itself - *what should I do?* The first seeking to establish universal norms, rules and principles that regulate actions, and the second analyzing the predictable consequences of actions to obtain the maximum benefit for the greatest number of people. Virtue ethics, on the other hand, emphasizes the role of the agent in ethical decisions - *how should I live?* or *what kind of person should I be?* In fact, how each person interprets and applies a certain principle or norm or assesses the usefulness of a certain course of action, always depends ultimately on their character and motivations[2].

The classical theories of virtue hold that virtuous people are best prepared to make the right decisions according to circumstances, not needing a moral code that tells them not to lie or harm others. As Roger Crisp and Michael Slote[3] point out, while for a follower of Kant the reason that one should not lie is because lying goes against the moral law, and for a utilitarian for not bringing the greatest benefit, for an advocate of a virtue ethics this is simply because it is a dishonest behavior.

Virtue as excellence

The Greek word for virtue, *areté*, refers to qualities not necessarily moral, and should be translated more correctly as excellence. The concept of *areté* was not only associated with human action. It was also an attribute of animals, vegetables, or objects. The *areté* of a rose was its beauty and pleasant aroma, the *areté* of a knife would be the greater the better it fulfilled its function of cutting. This ancient meaning of the term *areté* is found in the epic poems of Homer and Hesiod and was used by the sophists. The heroic virtues of Achilles, Ulysses, and other characters of the Homeric texts were exclusively masculine and included bravery, dexterity, patriotism, and honor[4,5]. The use of the term *areté* as excellence of character or moral excellence was introduced in philosophical reflection by Socrates, Plato, and Aristotle. This ethical-moral sense of the concept of virtue overlapped the original and is the basis of virtue ethics. The four cardinal virtues of antiquity – practical wisdom, temperance, courage, and justice – described by Plato in *The Republic* are virtues of character, relating to the conduct of man. According to this philosopher, these four virtues must be considered a unique entity so that we can live in harmony and are fundamental for the well-being and progress of the person and society[6].

Aristotle distinguishes between intellectual or dianoetic virtues, such as wisdom (*sophia*), science (*episteme*) and prudence (*phronesis*), which are related to knowledge and contemplation, and moral or character virtues, such as moderation or courage. He defines virtue as a trait of character of a person manifested in the usual action, which leads them to perform their role well (i.e. with excellence). Virtue is not just a feeling about what is good or a mere ability to make a correct choice. It is, above all, an active, voluntary, and persistent disposition to practice good in all circumstances and not occasionally and can be cultivated by teaching and practice. It is not simply a conditioned reflex, but an inner disposition or habit (*ethos*) directed by reason, regulated by practical wisdom or prudence (*phronesis*) and perfected by experience. This habit has a teleological quality, that is, it has in view a certain purpose or end (*telos*), which consists in fulfilling a certain task in the best way possible. Thus, we can say that virtue ethics is teleological because it is developed according to the specific ends of a given activity, not in the consequential sense of utility[2].

The Stagirite considers that moral virtues should seek the middle ground or equilibrium point between a defect and an excess, which should be avoided. This middle ground is universal, but it depends on individual characteristics and on circumstances, being determined rationally by practical wisdom[2]. The virtue of courage, for this philosopher, would be the middle ground between cowardice and fearlessness, the latter being excessive or inadequate trust; moderation would be the middle ground between detachment and dissoluteness; generosity, the middle ground between avarice and prodigality. Some authors consider this to be one of the weakest and most controversial ideas of the Greek philosopher[7,8]. One of the arguments that disarms the Aristotelian definition of virtue as the middle ground between two extremes is the impossibility of someone being exceedingly fair or honest or righteous.

The decline of virtues ethics in renaissance and modernity

In the realm of moral philosophy, the concept of virtue is considered a character trait of a person that leads them to act correctly in the usual way[2]. This understanding of virtues as a positive and appreciated moral quality was maintained during the classical and medieval periods, based on the works of Aristotle and Thomas Aquinas. Since the Renaissance, virtue ethics began to be devalued with the appearance of other theories of moral philosophy, particularly the Kantian duty-based ethics and the consequentialism of Jeremy Bentham and John Stuart Mill. As a result of the influence of rationalism and the works

of Machiavelli, Thomas Hobbes and Friedrich Nietzsche, there has been a progressive decline in virtue-centered ethics, although the last few decades have seen a recovery of this approach in moral philosophy and bioethics.

The Italian Renaissance politician Niccolò Machiavelli in his book *The Prince*, published in 1513 and considered one of the most famous treaties of politics, recommends what a ruler must do to remain in power. He uses the term virtue in the sense of willpower, cunning, violence, and domination, political and military, totally distinct from the usual meaning of Aristotelian roots. We find an example of the emphasis given to cunning in the following excerpt from Machiavelli's main work[9]: *Never has a prince lacked legitimate reasons to break faith. I could give you infinite examples from modern times, and show you numerous peace treaties and promises that have been broken and made completely empty by the faithlessness of princes: these knew well how to use the ways of the fox, and they are the ones who succeed (...) for the majority of men are simple and will only follow the needs of the present, so that the deceiver can always find someone he can deceive*. For this author, trying to live virtuously in a world where many do not do so puts his own survival at risk. In the wake of Machiavelli, as Pellegrino and Thomasma[7] observe, *physicians and lawyers are increasingly of the opinion that virtue and ethics are fine ideals, but that they are impossible to follow in our competitive, free-market, bureaucratized society*. This Machiavellian spirit, in the sense that virtues are considered an obstacle to success and prosperity, is present in a purely commercial conception of healthcare.

The English philosopher Thomas Hobbes, in the 17th century, developed a moral philosophy based on a pessimistic view of human nature, distinct from the classical-medieval perspective, clearly optimistic. According to this author, people are motivated by selfish interests, which manifest themselves in the desire to preserve their lives and enjoy pleasure, avoiding pain and harm from others. He considers that it is the individual's interest that determines what is good or bad, virtues and vices being a matter of personal preference. For the author of *Leviathan*, strength and fraud were virtues, and fame and profit should be the main human motivations[7]. Other authors, along the lines of Hobbes, tried to define the concept of virtue from psychology, genetics, or culture, such as the philosopher and writer Ayn Rand[10] in *The Virtue of Selfishness*, in which she defends the right of the human being to benefit from his moral acts and condemns the traditional perspective on virtues for considering it contrary to professional success and economic prosperity.

At the end of the 19th century, the German philosopher Friedrich Nietzsche rejected the traditional Judeo-Christian morality, and considered that the virtues were meant for simple mortals with a slave morality and not for the new and superior human being (*Übermensch*) he idealized. He should achieve "virtue" devoid of all moral elements, using the classical, non-moral meaning of the term[2]. According to the American historian Gertrude Himmelfarb[11], it was only in the 20th century that there was a marked relativization of the foundations of morality, so that traditional virtues were replaced by values. In her opinion, this was the greatest philosophical revolution of modernity, and Nietzsche, especially in his book *The Genealogy of Morals*, was the main protagonist of this paradigm shift.

At the beginning of the 20th century Max Weber, one of the founders of modern sociology, was the one who used the term *value* more widely although, unlike Nietzsche, without nihilistic intentions. In his book *The Sociology of Religion*, published in 1720, Weber uses the word *virtue* only when referring to religious virtues, and this reductive and sometimes pejorative connotation of the term has prevailed to this day. In today's society, the idea that many people have of virtue is related to sexual morality, being understood as chastity or marital fidelity[11]. However, while virtues are generally considered positive and meritorious habits or behavior that transcend the person, values do not always have the same meaning. In fact, they may not even be virtues, but only feelings, opinions, beliefs, preferences, or social conventions. They are what a person or a community values, thus having a subjective and circumstantial character. As Himmelfarb[11] points out, *one cannot say of virtues, as one can of values, that anyone's virtues are as good as anyone else's, or that everyone has a right to his own virtues*. Thus, to be faithful to the classical concept of virtue, we cannot replace it by *value*, which although more widespread in everyday language does not have the same meaning. All virtues are values, but not all values can be considered virtues[12]. For this reason, the eminent Portuguese physician and bioethicist Daniel Serrão[13] argues that *it is necessary to propose virtues, as incarnate as possible, and not abstract values laboriously created by generations of philosophers*.

The resurgence of virtue ethics today

One of the factors that contributed to a renewed interest in virtue ethics was the publication, in 1958, of the article "Modern Moral Philosophy" by the British philosopher Elizabeth Anscombe. In this essay, Anscombe[14] criticizes the supremacy of deontological and utilitarian ethics, which seek to establish universal moral principles to be followed by duty or obligation, as if human action were subject to a universal divine legislator in whom the proponents of these theories do not believe. She thus advocates a return to a virtue-based ethics of Aristotelian roots, more suited to the moral heterogeneity and secularization of modern societies. As a result of this insightful text written by Anscombe, other philosophers have sought to fill some gaps identified by this author in

Kantian and consequentialist ethics, developing virtue ethics approaches from these two influential models of moral philosophy.

The work *After Virtue* of the Scottish philosopher Alasdair MacIntyre[15], was perhaps the most remarkable and significant contribution to a wider acceptance of virtue ethics in contemporary moral philosophy and bioethical reflection. After a well-founded critique of the hegemony of ethical theories based on rights, duties, and consequences in today's society, he advocates the importance of a return to the Aristotelian-Thomistic tradition. MacIntyre argues that virtues are based on human professional practices or activities, and it is the responsibility of the executors of these practices to develop standards of excellence (which he called *internal goods*) appropriate to this activity. Virtues, for this author[15], are the qualities that allow one to attain the internal or intrinsic goods of a certain practice. The search for these goods will allow the establishment of moral communities that recognize the narrative unity of human beings and value their historical, sociological, and cultural legacy.

In the context of healthcare, ethical theories based on virtue and character have prevailed longer than in society at large, where, as we have seen, there has been a decline in this approach since the Renaissance. The Hippocratic Oath of the 5th century BC, the oldest code of professional ethics, was clearly based on a model of virtue and beneficence, and the same is observed in all treaties of medical ethics of antiquity, such as the Chinese or the Indian, as well as in the codes of ethics of Thomas Percival, James Gregory, and John Gregory, who practiced medicine in the United Kingdom in the 18th century[7]. Hippocrates urged the doctor to carry out his profession with purity and honesty. The Geneva Declaration of the World Medical Association, promulgated in 1948 following the Nuremberg Trials, states: *I will practice my profession with conscience and dignity,* and *I will maintain by all the means in my power, the honor and the noble traditions of the medical profession*. Most of these documents recognize that the care of patient cannot be provided exclusively through the fulfilment of deontological norms, being duty and virtue two sides of the same coin.

Since the 1970s, which corresponds to the period in which bioethics emerged as a new area of knowledge, there has been a paradigm shift in healthcare ethics, from a model based on virtue and on the inviolability of human life, expressed in the Hippocratic Oath, to a model based on the autonomy and quality of life of the patient, to which contributed the principlist approach of Beauchamp and Childress and the growing influence of utilitarianism on ethics committees.

In a seminal article entitled "The Metamorphosis of Medical Ethics", published in 1993, Edmund Pellegrino[1] points out that medical ethics had changed more in the last decades than over the 2500 years of its history. This metamorphosis of medical ethics, more evident and of greater proportions in the USA, but rapidly spreading to other countries, has profoundly altered the doctor-patient relationship, giving rise to new models, such as a commercial and a contractual, largely as a reaction to the paternalism of the Hippocratic tradition. Pellegrino[16] identifies some of the causes that contributed to this change, not all of them negative. They include profound transformations of a political, social, economic, and cultural nature, among which participatory democracy is considered the political system of choice, the growing moral pluralism and heterogeneity of modern societies, the influence of the media, the devaluation of the role of religion as a source of morality, the widespread mistrust of all manifestations of authority, and the increasing power given to doctors by scientific and technological advances.

Edmund Pellegrino and David Thomasma[17], the main representatives of virtue ethics in the context of healthcare, believe that it is possible to reach a consensus about the good of the patient and the virtues in professional ethics, after the nature and purpose of medicine, based on the phenomenology of the clinical encounter, contrary to what happens in society in general, pluralist and secular, where we are moral strangers. The emphasis of these authors on the character and virtue of the healthcare professional is based on a philosophy of medicine and on the principle of beneficence-in-trust in the doctor-patient relationship.

Virtue ethics and a more humane medicine

The main apologists of the ethical theories of virtue in bioethics and medical ethics have developed their thinking from the doctor-patient relationship. James Drane[18] proposes benevolence, respect, compassion, kindness, and justice as fundamental virtues of the doctor. Beauchamp and Childress[19] highlight four virtues in the activity of healthcare professionals: compassion, discernment, probity, and integrity. Edmund Pellegrino and David Thomasma[7], in their book *The Virtues in Medical Practice*, identify eight fundamental virtues from a phenomenological approach carried out within the philosophy of medicine: fidelity to promise, compassion, prudence, justice, courage, moderation, integrity, and altruism. All these virtues are related to the purposes of medicine and can be identified at the clinical encounter. Pellegrino[20] stresses that these character traits are included not because they are excellent, but because they are essential to fulfil the objectives and purposes of medicine. These purposes stem from the reality of the doctor-patient relationship and not from social conventions, consensus or agreements. In other publications, Pellegrino[21] also mentions benevolence, care, intellectual honesty, humility, and truthfulness, and points out that other virtues could also be added.

According to Pellegrino and Thomasma[7], the aim

of virtue ethics is the search for excellence, in which one intends to "hit the target", that is, to fulfil the purpose of carrying out a certain action in the best way possible. This purpose is much more demanding than the fulfilment of deontological norms or legal obligations, placing the target on a higher level than the strict observance of the letter of the law. According to these authors, the greatest difference between this ethical theory and the deontological and consequentialist theories manifests itself in the approach to the most ambiguous and controversial ethical problems. Healthcare professionals who govern their acts according to a virtue ethics perspective will not participate in certain activities about which the law is omissive or condescending. On the other hand, the professional who governs their conduct according to a virtue ethics approach does not make their decisions to be appreciated or recognized by their peers or by society, nor do they consider self-benefit as the main motivation for their conduct. They try to act correctly in all situations, both in public and private[7].

We will then briefly present the eight virtues that Pellegrino and Thomasma consider indispensable for the exercise of the medical profession. The observance of these and other virtues will contribute significantly to alleviating the recognized lack of humanization of healthcare services, which is the most pressing ethical problem in the practice of medicine.

Fidelity to trust

We can define this virtue as being the commitment or fidelity to the promise that the doctor solemnly swore to fulfil to put their knowledge and skills at the service of the good of the patient, based on a relationship of trust between both. For Pellegrino and Thomasma[7], trusting someone implies becoming vulnerable and dependent on the good intentions of the person we trust. This fact is even more notorious and has deeper consequences when we find ourselves in states or phases of life of greater dependence and weakness, as occurs in illness, childhood, or old age. If we seek help in case of illness, which may involve anxiety, pain, or suffering, we are *obliged* to trust that the professionals we turn to have made a solemn commitment to take care of us and that they will protect our vulnerability[7]. In clinical practice this relationship of trust has an intrinsic therapeutic value and includes the fulfilment of some more trivial promises (e.g., I will come back later to talk to you) which, if made, must be fulfilled.

One of the consequences of the decline in trusting doctors in recent decades is the determination of a growing number of patients to do their own research on the symptoms they present, doing tests or even experimenting with certain treatments on their own initiative, or even resorting to alternative therapies, most of them lacking scientific credibility. This is a model, in our view unsatisfactory, in which the doctor plays the role of a mere technician or service provider, being a simple resource among many others. On the part of the doctor, this climate of mistrust and latent hostility promotes a defensive decision making in order to avoid the risk of lawsuits, which in the American context are often motivated by economic purposes, aiming at a large compensation, and not for a real feeling of having been the victim of an act of negligence or bad clinical practice. However, as Bernard Lown[22] points out, studies have systematically demonstrated that patients are more likely to initiate a lawsuit against healthcare professionals, not so much because of medical error, but because they are displeased with communication and lack of empathy in the doctor-patient relationship.

It is understandable that the trust patients place in the doctor does not automatically arise because the doctor is a specialist or competent in a particular scientific area. It develops through dialogue during the clinical encounter, from the first moment, and grows up over time. It does not confer privileges to the professional but brings responsibilities and values patient's autonomy[7]. However, trust is fragile and can be easily broken by some failures on the part of the physician, such as not clarifying doubts or questions posed by the patient about the clinical problem that concerns them or not providing the results of an analysis or examination already performed. In the clinical context, it may lead to the patient's concealment of some details of the history of the present disease that could be determinant to reach the correct diagnosis and begin appropriate treatment.

A trust-based approach is clearly a virtue ethics, as it does not depend only on the legalistic fulfilment of principles or deontological duties, but also on the character of the professional. The alternative to the solemn commitment to promote the patient's good (fidelity to trust) is to reduce the medical act to a mere commercial contract, considering healthcare as a consumer product and providing managers to monitor and supervise the work of healthcare professionals.

Compassion

The word *compassion* is composed from the Greek words *com* (with, together) and *pathos* (feeling, to suffer). For Pellegrino[23], *it denotes some understanding of what it means for the other person to be sick, as well as a readiness to help and to see the situation from the perspective of the patient*. There are many studies that highlight the importance of compassion or empathy in the context of healthcare, particularly in terms of greater adherence to therapy, greater overall patient and doctor satisfaction, lower risk of medical burnout, and a decrease in the number of lawsuits for medical malpractice[12]. If compassion is not present in the medical act, there is the risk of treating the patient coldly and distantly, as an object of clinical curiosity.

Compassion incorporates an ethical dimension, which has to do with the commitment adopted by the doctor to use their professional skills to promote complete

restoration of the patient's health. It also includes an intellectual dimension, which consists of an objective and rational evaluation of the patient's problem, in view of its resolution, tempered by recognition and respect for their life history, language, feelings and values[7]. However, an excessive identification of the clinician with the suffering of a certain patient can be counterproductive, as it can limit their professional responsibility towards this patient, by hindering the necessary discernment for a correct diagnosis and the choice of the most appropriate therapy[7]. Therefore, many codes of medical ethics and deontology recommend that, in general, doctors should not treat their own relatives.

Pellegrino and Thomasma[7] stress that there must be a balance between the virtue of compassion and technical and scientific competence, being the virtue of prudence the middle ground in this relationship. Moreover, it is important to mention that these authors value competence in clinical practice in such a way that they consider it a moral imperative and are aware that there are occasions when competence should prevail. For example, in a delicate surgical intervention such as a coronary artery bypass grafting or the repair of an aortic aneurysm.

Prudence

This moral and intellectual virtue, called *phronesis* by Aristotle, represents practical wisdom, that is, the ability to discern which path is best to follow, after pondering the circumstances involved at a given moment. In the context of medicine, it is the virtue of prudence that makes clinical judgment possible, leading to the correct diagnosis and institution of the best therapy for real people, debilitated by disease, taking into consideration their personal history and value system, as well as the uncertainty inherent to any medical act[7].

It is an indispensable virtue for the practice of medicine, since every medical act involves an intellectual and an ethical dimension, and prudence allows the integration of technical and scientific competence with the hierarchy of values. A decision may be medically correct from the scientific point of view, but it will only be a decision ethically acceptable if it takes into consideration the value system of the individual patient. In this sense, prudence is one of the most important virtues and is present in all decisions that are made in medical practice.

Up until the 1970s, patients usually accepted doctors' decisions in a passive way, what has been called medical paternalism. Nowadays, the respect for the patient's autonomy requires the obtaining of a free and informed consent before any medical act, as well as the acceptance of the patient's freely expressed will not to undergo a certain medical or surgical treatment, even if this decision may reduce their life expectancy[7]. Occasionally, when the clinician anticipates that disclosing complete information of the patient's medical condition may lead them to despair and to commit self-harm or suicide, it may be legitimate to resort to the so-called *therapeutic privilege*, and it should be postponed to a more favourable occasion[7]. This attitude is distinct from the so-called *noble-pious lies*, which for many years had been common practice with patients with severe diseases and poor prognosis. It was given more importance to the Hippocratic principle of confidentiality than to the virtue of truthfulness, since it was thought that revealing the truth would be harmful to the patient. Since the 1970s, with the recognition of the patient's autonomy and the legal obligation of obtaining informed consent, this attitude of concealing the truth has fortunately been abandoned. In the process of acquiring consent the virtue of prudence must be present so that the doctor transmits to the patient balanced information (neither insufficient nor excessive) and at the appropriate time (neither too soon nor too late), with respect for his autonomy and vulnerability.

Justice

Justice is one of the four *prima facie* principles proposed by Beauchamp and Childress, being the only one that is simultaneously a virtue. Justice as a virtue is a trait of character and can be defined as the habit of retributing or giving back to others what is due to them. Pellegrino and Thomasma[7] consider justice as one of the most complex virtues since all human relationships, by their very nature, are always imperfect and limited, even in ideal circumstances, and it is not possible for someone to be overly righteous. These authors[7], in the wake of Aristotle, distinguish between distributive justice, related to the common good, which has to do with the equitable distribution of resources according to the principle of equality among citizens, and commutative justice, which relates to the individual good and requires the doctor to consider the specific needs of the patient. However, they emphasize that the essence of the virtue of justice always resides in the good for the individual, even when public or community health issues are discussed[7].

The virtue of justice may involve setting priorities in patient care. Considering that the available resources will always be insufficient, for a population or a country, decisions should be based essentially on clinical criteria, supported by credible and updated scientific evidence, namely in the prescription of medication and the proposal of surgeries and other medical acts. However, preference should be given to the lowest cost options, which becomes even more necessary in situations of economic crisis, provided that such a decision is appropriate to the patients' clinical condition and does not endanger their lives. As Pellegrino and Thomasma[17] point out, the doctor must seek *diagnostic elegance*, which consists in resorting to the minimum number of complementary exams necessary for diagnosis, as well as *therapeutic parsimony*, which means proposing of treatments that are proven, beneficial and effective. These authors[24] propose some measures to contain health expenditure that could be implemented, instead of the

lack public funding of treatments considered indispensable, especially for citizens of low socioeconomic status. They include the use of less expensive complementary exams, if they allow the diagnosis to be made, the elimination of unnecessary exams and interventions, such as those carried out in the context of defensive medicine, the use of less expensive therapeutic approaches, although of proven efficacy, or the non-reimbursement of aesthetic treatments.

Courage

Pellegrino and Thomasma[7] explain that by including courage in the list of medical virtues, they are referring to moral courage, although sometimes it is necessary for the doctor to display also physical courage, especially in scenarios of war or natural disasters, as well as in the exercise of the profession in countries where there are potentially serious endemic diseases. The authors recognize that this virtue is one of the most neglected and difficult to put into practice in contemporary society, following the enormous transformations that have occurred in recent years in the provision of healthcare, in which there has been a decrease in the influence of doctors in relation to political and economic agents. The virtue of courage consists in defending what is thought to be right and true and resisting what is known to be wrong, often against indifference, silence, and resignation.

Some behaviors that Pellegrino and Thomasma[7] consider unacceptable, for violating the doctor's primordial commitment to the patient, are his participation in acts of torture of prisoners or compulsive internment, in psychiatric units, of political dissidents or of citizens hostile to a certain political regime. The opposition of doctors to these practices or their refusal to obey the orders of totalitarian governments will require a high dose of moral courage and may involve risk of life. However, these are unusual situations in democratic societies, and the virtue of courage is most often manifested in the defence of the most vulnerable and disadvantaged, in reporting fraud or incompetence, in drawing attention to healthcare deficiencies, and in the contribution of doctors to the public debate regarding the allocation of health resources, considering the needs of the most deprived[7].

A characteristic of virtues in general, and even more notoriously of moral courage, already reported by Aristotle, is that it is a voluntary, reflected, individual and non-coercive choice, although there may be opposition and the risk of possible retaliation. The fear of being the target of a lawsuit may lead the clinician to practice defensive medicine, requesting unnecessary exams, prescribing dispensable treatments, or avoiding intervening in complex cases or of poor prognosis. Courage may be required to resist the fear of litigation, particularly fierce in American society, or not allowing the interference of external factors, political or economic, in the relationship of trust that must exist between doctor and patient[7].

Temperance

In the context of medicine, this virtue can be defined as the willingness of the clinician to make judicious use of the means provided by modern technology, avoiding its excessive or disproportionate use, what some call therapeutic obstinacy, or on the contrary, the underutilization of resources potentially beneficial to the patient[7].

Due to the current t, in developed countries, to use the entire therapeutic arsenal and state-of-the-art technology in patients whose benefit from the use of these means will be questionable or marginal, Pellegrino and Thomasma[7] argue that it is necessary to exercise the virtue of moderation to counteract it, not only considering the interest of the individual patient but also the social obligation of a judicious use of limited resources. However, they argue that it is equally intolerable to abandon patients and not treat reversible pathologies due to economic constraints or complex situations due to the risk of being subject to disciplinary or judicial proceedings[7]. In the opinion of these authors[24], it is easier for the healthcare professional to resort to technology in an attempt to solve a clinical problem than to interact with the patient, listening to their wishes and answering their questions, as should happen with the legal obligation of getting an informed and free consent before any type of intervention. The indiscriminate use of available techniques may contribute to a greater suffering of the patient and his relatives, postponing an inevitable death at the cost of reducing his quality of life and wasting resources that could benefit patients with chronic diseases or better prognosis. It is a form of abuse of power, superimposing medical paternalism on respect for the autonomy and vulnerability of the patient, which the exercise of the virtue of moderation will help to resolve.

Integrity

The word integrity derives from the Latin term *integritate*, which means the state or quality of the whole that has all its parts, and which lacks nothing. It includes the notions of wholeness, fullness, character of what cannot or must not be broken or modified. As a virtue, it encompasses the concepts of moral wholeness, honesty, righteousness, probity, and impartiality. A person is said to be whole when they act according to a certain set of values and moral principles, in which they believe, and presents an honest, impartial, upright, incorruptible, fair, and true behavior. In the exercise of medicine, situations that compromise the moral integrity of the doctor or the patient should be avoided, in respect for the value system of each one[7].

The clinical decision must be consistent, rigorous, and rational, based on anamnesis, physical examination, and possible complementary examinations, so that the doctor should not be a simple technician or bureaucrat. The doctor will make decisions according to their knowledge and conscience, not yielding to pressures nor any kind of

bribe. It will be unacceptable for the physician to accept any payment, whether in goods or money, to facilitate the scheduling of an appointment, examination, or surgery. Likewise, doctors should not prescribe superfluous medication, request unnecessary complementary diagnostic tests, or propose unnecessary clinical procedures or surgeries. In the private healthcare sector, or when the remuneration is dependent on productivity, there may sometimes be the temptation to perform complementary exams, surgical interventions or treatments which are superfluous, in view of the financial compensations. However, one should not fall into the opposite error of failing to do what must be done, for the benefit of the patient, which may constitute medical negligence. According to Pellegrino and Thomasma[7], doctors are sued for doing too much or too little.

Doctors manifesting integrity will avoid situations where conflicts of interest may arise, particularly with the pharmaceutical industry, and will never accept the intrusion of these companies in their clinical activity. Likewise, they will avoid promiscuous or non-transparent relationships with the industry when conducting clinical trials or publishing the results of such studies in scientific journals[25].

Altruism

Altruism or self-effacement, that is, putting the good of the patient above personal interest and without expecting any compensation is, according to Pellegrino and Thomasma[7], one of the most difficult and least popular virtues in the practice of medicine in contemporary society. In the current context of market economy, with the progressive commercialization of healthcare, even in the public sector, altruism and beneficence are devalued, while there is a legitimization of self-interest and economic prosperity. The authors recognize that society continues to disapprove and penalize certain acts that are recognized as immoral in medical practice, such as incompetence, fraud, deceit, illicit use of funds, breach of confidentiality or sexual abuse. However, what worries them most are certain practices that are on the *fringes of morality*, many of them legal, accepted and tolerated by modern society, such as restrictions on access to healthcare services by the poorest citizens, without health insurance or other forms of conventional medicine, or the abandonment of more complex cases or of poor prognosis by the emergency services, in order to avoid the risks of malpractice lawsuits. Such practices and attitudes are in a grey zone where the boundaries between right and wrong are blurred but are still ethically questionable[7].

Altruism is not an absolute value, but when present in professional practice it confers greater authenticity to the doctor-patient relationship and greater independence from economic constraints. This is because there are potential conflicts of interest in the clinical encounter, between the individual interest of the doctor and his responsibility towards the patient. Such conflicts are not only financial, but may involve the family, the profession, the academy, or even political parties and trade unions, which can undermine the doctor's primary commitment to the individual patient. As Pellegrino and Thomasma[24] recall, *for centuries, good physicians have treated patients who could not pay, have exposed themselves to contagion or physical harm in responding to the call of the sick, and have sacrificed their leisure and time with their own families – sometimes too liberally – all out of commitment to serve the good of the sick. Indeed, it is this effacement of self-interest that distinguishes a true profession from a business or craft.*

Virtue-based ethical decisions are an example of supererogatory acts, that is, acts that are beyond what is required by duty[7]. No healthcare professional will be praised for complying with the rules and duties addressed in the Code of Ethics of the Medical and Nursing Associations, but rather for seeking ethical and moral excellence in their conduct.

However, it is not only healthcare professionals who should manifest virtues in the clinical relationship. There are virtues that patients must reveal to fulfil the purposes of medicine, such as honesty in disclosing their clinical history, without omission or distortion of facts, or moderation with respect to eating habits, alcohol consumption, tobacco avoidance and sedentarism. According to Lázaro and Gracia[26], the traditional idea of a *good patient* is that of someone docile, submissive, respectful, obedient to the doctor's indications and not asking too many questions. It is like the expectations that many parents idealize in relation to their children. For Pellegrino and Thomasma[7], this paternalistic model of the doctor-patient relationship is not legitimate and has never been, and they maintain that patients have duties and responsibilities in their clinical encounters, and must manifest virtues such as integrity, justice, tolerance, trust, benevolence, humility, and courage, in addition to the honesty and moderation already mentioned.

To practice medicine with competence, tempered by the virtues we have described, is more difficult and demanding, but it is the best way to professional satisfaction in exercising the noble profession of medicine.

CONCLUSION

Dr. House, a character from the popular TV series, portrays a certain way of practicing medicine in our time. Famous for his irreverence, assertiveness, and brilliance in the way he solves the rarest and most complex medical problems, he reveals a deep lack of character in his relationships with colleagues, with other professionals and with the patients themselves[27].

All patients wish to be treated by the best professionals, competent in the specialty they have

embraced, outstanding performers of the most modern and sophisticated technologies, recognized by their peers due to academic and professional successes. However, they also wish to be cared for by doctors whom they can trust, who know how to listen to them with attention and empathy, who can answer their doubts and concerns in a satisfactory manner. In short, patients wish to be treated with the dignity and respect they deserve, and not as objects of clinical curiosity or source of income.

What kind of doctors do we want? How would we like to be attended and treated when we need medical assistance? Certainly, Pellegrino's[28] description meets the wishes of most people. If we can choose, we would certainly like to be treated by *a virtuous physician, a "good physician", one who does his work well, who understands your vulnerability, professes to be able to help and is faithful to that promise. What you do not want is the entrepreneur, the businessman, the technician, the bureaucrat, the jobholder, the man who presumes to know it all or sees you as an object of exploitation.*

Deontological codes and professional ethics do not ensure that medical practice is always well-intentioned and exemplary, because the basic element of the exercise of the profession is, as it has always been, the character of the healthcare professional, with virtues being the ethical and moral foundation of their activity. Thus, the exercise of medicine and healthcare based on a virtue-ethics approach is fundamental for a more humane medical practice that takes into account the patient's good, and will also contribute to counterbalance the hegemony of principlism and ethical theories that devalue the central role of the agent in contemporary moral philosophy and bioethics.

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