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Surprising pandemic experiences: A confrontation between principle-based and virtue ethics, and a plea for virtue ethics training for medical students and residents. A rudimentary outline of a four-step model

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Abstract

Background: In past years, physicians have, with a certain continuity, reported increasing numbers of burnout, depression and compassion fatigue in their daily practice. These problems were attributed, not only but also, to a loss of public trust and an increase in violent behaviour of patients and family members towards medical professionals in all walks of life. Recently, however, during the breakout of the coronavirus disease 2019 (COVID-19) pandemic in 2020, there were public expressions of appreciation and respect for health care workers that almost universally have been assessed as indications of a re-establishment of public trust in physicians and appreciation for the medical professions' commitments. In other words, shared experiences of what society was in need of: the experience of a 'common good'. Those responses during the COVID-19 pandemic increased positive feelings among practicing physicians, such as commitment, solidarity, competency, and experiences concerning obligations for the common good and a sense of belonging to one and the same community for all. Essentially, these responses of raised self-awareness of commitment and solidarity between (potential) patients and medical personal point towards the social importance and power of these values and virtues. This shared domain in ethical sources of behaviour seems to hold a promise of overcoming gaps between the different spheres of doctors and patients. That promise justifies stressing the relevance of this shared domain of Virtue Ethics in the training of physicians.

Methods: In this article, therefore, we shall make a plea for the relevance of Virtue Ethics before proposing an outline of an educational programme for Virtue Ethics training for medical students and residents. Let us start by very briefly presenting on Aristotelian virtues and its relevance to modern medicine in general, and during the current pandemic in particular.

Results: We shall follow up this short presentation by a Virtue Ethics Training Model and the respective settings in which it takes place. This model has four steps as

follows: (a) include moral character literacy in the formal curriculum; (b) provide ethics role modelling and informal training in moral character in the healthcare setting by senior staff; (c) create and apply regulatory guidelines regarding virtues and rules; and (d) assess success of training by evaluation of moral character of physicians.

Conclusion: Applying the four-step model may contribute to strengthening the development of moral character in medical students and residents, and decrease the negative consequences of moral distress, burnout and compassion fatigue in health care personnel. In the future, this model should be empirically studied.

KEYWORDS
evaluation, humanity, medical education, medical ethics, philosophy of medicine, virtue

1 | INTRODUCTION: A BRIEF ON VIRTUE ETHICS AND PRINCIPLE-BASED ETHICS

Virtue Ethics is the oldest branch of ethics usually distinguished from later types of ethical theory, such as utilitarianism (consequentialism) and Kantianism. Consequentialism holds as an axiom that whether an act is morally right depends on the consequences of that act or of something related to that act, such as the motive behind the act or a general rule requiring acts of the same kind.[1] It is also distinguished from Kantian deontology, a model maintaining the idea that what makes a choice right is how it conforms with an abstract moral norm. That is, if an act is not in accord with that norm or duty, it may not be undertaken, no matter the good that it might produce.[2] Principle-based ethics moves from the abstract to the mundane. Virtue ethics emphasizes the moral importance of the agents who perform actions and make choices by looking at reliable character, moral good sense and emotional responsiveness.

A virtue is a trait of character that is socially valued and a moral virtue is a trait that is morally valued. In addition, virtue is intimately connected to characteristic motives. Properly motivated persons often do not merely follow rules; they also have a morally appropriate desire to act as they do.

Bioethics or principle-based ethics employ deductive reasoning from a preset of principles (values, rights) that are applied to specific issues. There are four principles that are generally recognized and agreed as starting points for analysis. These are as follows: autonomy or self-determination, nonmaleficence, beneficence and justice. The application of this type of ethical methodology from its onset has been successful in becoming a demi-institution that it has become today, even though its lack of sensitivity to social inequalities in health care and individual patient preferences has been well recognized. Bioethics became successful, because its programme and procedures were a clean fit within the medical power structures of a neoliberal society with its social and economical priorities. In this specific order, in the words of Koch: 'consumerism and transactional thinking are advanced, in the name of individual autonomy, over the values of community and communal responsibility'.[3,p. 9]

Between these principled ethical theories and the principles of virtue ethics is an overlap but also a distance, in spite of attempts to combine the two theories, attempts that are described by some like Pellegrino and Thomasma[4] as less than successful because of the large concentration on principles. For others, such as in Koch's[5] '*Thieves of Virtue. When Bioethics Stole Medicine*', the descriptions of principle-based ethics focuses on the problem of separating reason 'from' everything that gives meaning to it in the medical relationship. 'The result is not moral vision but fragmentation; not grounded ethics but an emptiness outside any social or ethical tradition'.[3,p. 13] One can take that position one step further, as Clark[6] describes in his article on 'Trust in medicine', in the *Journal of Medicine and Philosophy*, quoting Pellegrino: 'Pellegrino sees trust in medical relationships to have deteriorated significantly. He notes that as patients perceive doctors as less interested in them than in their money, more interested in time off than service, and more exploiters than stewards of medical knowledge, the climate of medical relations between physicians and patients becomes one where an atmosphere of wariness replaces trust'. Clark[6] then continuous with how that deterioration of trust parallels today's problems of the medical profession: a malpractice crisis, a legalistic atmosphere surrounding treatment, commercialization of medical care, 'pay-before-we-treat' policies, depersonalization of treatment and a retreat from general to specialty practice'. Here is a clear connection with the loss of trust between public and medical profession.[7,p. 13]

Even though Beauchamp and Childress[8] pay much attention to the place of virtue ethics in the closing Chapter 8 of their seminal *Principles of Biomedical Ethics*, the weight that they impute to virtues does not seem adequate to allow sensitivity to individual choices and social inequalities. Even though there are as many different virtue ethics theories as there are principle- and rule-based ethics, there still is a call for rethinking the wealth and opportunities of virtues, as can be seen in calls for a return to virtue ethics in general. Essential is space and sensitivity in the ethics deliberations for the virtues of both medical professionals at all levels and those of patients.

Modern versions of Virtue Ethics employ mostly three concepts derived from it. These are arête (excellence or virtue), phronesis (practical or moral wisdom) and eudaimonia (usually translated as happiness or flourishing).[9]

Aristotle's[10] Nichomachaen Ethics, now more in detail, emphasizes the characteristics that a person adopts by doing good over time, to achieve excellence in acting morally. Aristotle[10] describes in his writings 12 spheres of action or feeling of human experience. These spheres are as follows: (1) Fear and confidence, (2) Pleasure and pain, (3–4) Getting and spending (minor and major spheres), (5–6) Honour and dishonour (minor and major spheres), (7) Anger, (8) Self-expression, (9) Conversation, (10) Social conduct, (11) Shame and (12) Indignation. He describes both the excess and deficiency of each sphere. He argues that the mean characteristic of the fundamental expressions in each sphere is the good virtue.[10] Aristotle and his successors in modern Bioethics, to take a leap, notably Nussbaum,[11] consider these virtues related to the spheres of human experience including courage, temperance, liberality, magnificence, proper ambition/pride, patience/good temper, truthfulness, wittiness, modesty and righteous indignation. The spheres and respective virtues, as Nussbaum[11] notes, are relevant to modern times, in particular at a crisis of faith in local and global leadership. This, we argue, is true in particular regarding the management of a pandemic.

Virtue Ethics could be supportive in this context and encourage health care professionals to consider their own actions in regard of particular virtues. Starting from an abstract virtue such as phronesis, one can train health care professionals to become and act more sensitive in response to a moral problem. As Aristotle wrote, moral excellence can only be achieved by doing actions over and over again, meaning that time and again, faced with particular situations and contexts, professionals can be trained in acting better. We can also think of other virtues such as fairness, honesty, judgement, kindness, leadership and teamwork. Health professionals need to be able to resolve dilemmas in the daily routine by deliberation with bravery and social intelligence, but also to become better persons.[12] Virtue ethics might be of help in this context.

Recently, a probably not intended but nevertheless strong support for our ideas can be seen in a paper by Hardman and Hutchinson.[13] They provide, in just a few pages of four case descriptions, both an excellent critique of application of principles of ethics in their analysis of the customary distinction between what is medical and ethical. In addition, they call for the cultivation of 'a greater understanding and of sensitivity towards their patients' everyday life'.

Medical and ethical aspects classically are considered as if these two are clearly different and additional domains of fact and value in medicine. Their argument is that values however are primarily always involved in determining what a medical fact is. The 'ethical' is interwoven into the 'medical' and not additional: 'the good doctor already delicately weaves the ethical and the medical in the exercise of their distinctively clinical practical judgement'.[4,14,15,p. 46] Medical and ethical, both are aspects of an ethical situation, 'in particular, everyday concerns, which are often resolved in a shared and negotiated cultural background'.

According to the authors uncovering what is medical requires specialized training with a focus on biomedical aspects, with a tendency to estrange and develop barriers towards understanding patients' backgrounds. To overcome these barriers, they argue for the above mentioned 'cultivation of greater understanding and sensitivity towards their patients everyday life' through a focus on activities that ground ethics in everyday human concerns, through, among others, 'exposure to patient's accounts of their illness experience' and 'exposure to literature and theatre'.[14,p. 47]

The authors seem to be slightly ambivalent about the methods to employ in reaching those goals. On the one hand, they see a role for 'adaption of the teaching of ethics in medical schools for this cultivation of understanding and sensitivity', and they appeal to 'more opportunities for active rehearsal and improvisation in simulated clinical settings'. However, they also express some hesitation about present approaches to teaching, to 'thinking ethically', 'as a process informed by the application of and reflection on the competing merits of special principles'.

This last position and the above analysis are exactly the main line and the overall content of this paper in describing a broad teaching programme on 'virtue ethics'.

Let us focus also on when the values of virtue ethics tend to come in conflict with the reality of medical practice. In the past century, there has been a transformation in the physician–patient relationship and its implications for the quality of care, such as adhering to recommendations[16] and what constitutes functional health.[17]

The 'country doctor' of the twentieth century[18] is a far-gone figure. Today, in many western health care systems, there are barriers to expression of physicians' compassion towards patients, such as in the short time allocated for consultations, specialization, especially in General Practice and Internal Medicine.[19] Surprisingly, medical education, both schooling and residencies, rather tend to lead to a decline in the skill of applying empathy even though the profession seems to realize this and strives for compromises.[20] Along these same lines, practitioners are concerned about possible legal implications of transparency towards patients and seem to feel threatened by disclosure of medical errors in spite of its proven value for patient safety.[21] Oftentimes, physicians feel unsafe about the institutional reactions in case of complaints against them.[22] Then, there is always the empowered patient of the twenty-first century as well,[23] who is well-educated about rights and options for second and even third opinions for conflicts between patients and physicians.

This list of changes in health care practice forms a complication for the generally recognized importance of long-term stable physician–patient relationships.[24] And then, at the very onset of the current decade, along comes the coronavirus and turns the medical reality upside down, as we discuss in the next section.

2 | VIRTUES AND THE THERAPEUTIC RELATIONSHIP DURING THE CORONAVIRUS DISEASE 2019 (COVID-19) PANDEMIC

In the past decade, violence towards medical teams has been perceived as an expression of a lack of trust of patients in physicians.[25] In Israel, this phenomenon recently has been

recognized[26] and attempts to address it have been put in place.[27] The common line was that patients' reported feeling that their values and wishes were not essential for the patient–clinician exchange, not even when life-changing decisions were in order, like in an intensive care unit (ICU).[10]

In this atmosphere, in February–March 2020, COVID-19 arrived in full speed in the (Western) world and, for over a year, both hospitals and community health care interactions have been conducted through masks, screens, video calls and webcams. Interactions as such were performed by many specialties including family physicians, paediatricians, geriatricians and psychiatrists. Life-changing conversations were conducted via video calls, in particular regarding advanced care planning and do-not-resuscitate conversations.[28] In ICU's, medical teams used video calls routinely for the management of end-of-life decisions and care.[29] At the same time, people outside the 'medical world' in the public spheres were applauding in streets and on balconies throughout the early phases of the pandemic, first in Italy and later on in other countries across the board. In addition, outdoor advertisements in public acknowledged the physicians' devotion towards patients and expressed gratitude of patients and families. This show of regaining the public's appreciation probably may have contributed to the wellbeing of physicians, in feelings of competency, autonomy and belonging with a decrease in burnout, although maybe only for a short period.[30] 'Covid' did not take away the problematic effects of an increase in workload and/or hostility towards health professionals that are part of the new reality. However, the public appreciation towards the medical profession, and learning how to cope showed the possibility of shared virtues, as is the object of virtue ethics training.

Despite or because of the major public health emergency, recent studies portray a newly discovered certain appreciation between patients and clinicians, as the two ends of the therapeutic relationship are safely located at their natural environment. At home or in a clinic, they can shield their barriers[31] and get to know each other better and feel closer.[32] Virtue wise, the introduction of a physician to the day-to-day routine of the patient, who is quarantined or at home hospitalization using video or phone calls, seemed to increase the compassion of a caregiver, as well as discernment and sensitivity to patients' anxieties and needs. This newly gained competence by physicians, feelings of both autonomy and belonging, seemed to allow personal feelings of being less judgmental, with more kindness and honesty.

As the pandemic spread out, the emergence of what was called a Rapid Response Compassion Fatigue among health care personnel has been widely discussed. It is characterized by physical, emotional and spiritual fatigue of health care teams. Ramanujapuram,[33] for example, describes how physicians who are suffering from burnout, compassion fatigue and other psychological symptoms keep devoting themselves to patients. Nevertheless, they find it hard to realize a balance in treatments between empathy and objectivity. Consequently, they experience oversensitivity, a lack of emotional regulation, helplessness, a low self-esteem and a lack of clarity regarding their goals.

What now seems essential is to realize and aim to maintain the shared experience between the public and the medical profession during the Covid-19 pandemic and reinforce the foundations of these shared experience. Central to these experiences are values as solidarity, commitment, openness/intimacy, trust, mutual appreciation and gratitude for service provided. The idea behind this programme is that both public and profession will gain from rules and regulations founded on these shared values, which had been proven effective during the pandemic.

Introducing Virtue Ethics in training and practice, as part of the curriculum of students in their preclinical years and throughout residency, seems to be essential. Moreover, a virtue-oriented curriculum may actually lead to a decrease in moral distress and in compassion fatigue associated with the Covid-19 pandemic and postcrisis.[34] In this process of trying to become a virtuous person, by practicing good virtues for a longer period, both parties in the therapeutic relationship may or will benefit. Patients will gain from a generous, honest, compassionate caregiver who, as Blum[35] shows, holds the right ethical perceptions and luggage, may suffer less from burnout, depression and guilt feelings, arising from a conflict between wishing to do good and being unable to reach too high aspirations.

In the following sections, we shall discuss the role of integrating 'virtues' in medical practice and suggest a four-step model of Virtue Ethics training for the clinical years of medical school and during residencies.

3 | THE EDUCATIONAL METHOD: A FOUR-STEP TRAINING MODEL

We shall base our proposal on the ideas of the '*Jubilee Center for Character and Virtues*', as published in Britain in 2015 in its 'Virtuous Medical Practice' report.[36] The report is based on a multimethod study of 549 first- and final-year medical students and experienced doctors. Its recommendations were to:

1. Include 'literacy of character' in the formal curriculum of initial medical education,
2. Increase ethics role modelling and informal training in moral character in the workplace by senior staff,
3. Provide regulatory guidance regarding virtues and rules, and
4. The most difficult task, as put in their words, 'if virtue-based approaches are to match the impact that the rule-based approaches already have, they must begin the (complicated) process of developing valid, reliable and fair means to assess doctors' moral character'.[33,p. 10]

According to a former medical student, Lyon[37], 'Teaching practical ethics to medical students is already done on the wards and in the clinic, for example, when a physician explains the approach to a particular ethical dilemma. However, students and trainees lack a coherent framework within which to understand these sporadic lessons in moral decision-making. By introducing the theory, or

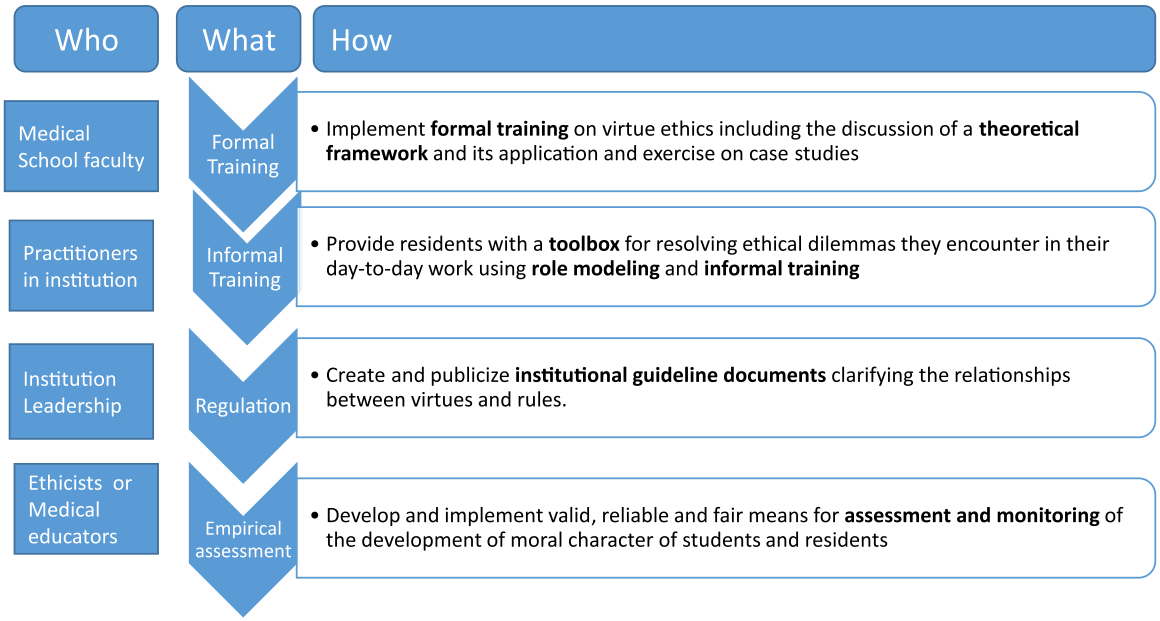

FIGURE 1 The four-step model for virtue ethics training.

science, of virtue to medical students earlier on (e.g., in the first 2 years), they hopefully will be better equipped to notice and practice the art of moral decision making'. The next section will describe the outline of our suggested model for such a training programme, a model that requires empirical evaluation.

In a training programme for virtue ethics, we suggest to use the following four-step model, based on the Jubilee report. The model is described in Figure 1.

In accordance with the Jubilee report, the model includes four components. The first is an educational programme, which is included in the clinical years at medical school, and the second is an educational programme for the hospital department or clinic. The third component is an adjustment of the regulatory basis to include relevant guidelines and the fourth is continued assessment of moral attitude (character?) of medical students and residents.

4 | HOW DOES THIS FOUR-STEP MODEL WORK?

With a focus on the components in more details:

1. In roughly the past two decades, the traditional ethics syllabus of medical schools around the globe focuses on the 'four principles of Beauchamp and Childress',[8] which, according to empirical studies, are firmly embedded in the physicians-to-be dialogue.[38] The scope of Virtue Ethics in the existing formal curriculum of medical students and the adequate setting of teaching it is, however, unclear, despite its potential role in designing the desired professional identity of future physicians. According to Strachan,[38] 'it is incumbent upon medical educators and the profession as a whole, to ensure that as future doctors, medical students develop the virtues that are at the heart of medicine's professional identity, allowing us to connect with our patients as fellow humans.'[37,p. 89]

As a first stage, then, it is crucial to provide medical students, preferably in the clinical years, formal training on virtue ethics including the discussion of a theoretical framework and its application and exercise on case studies. Virtue ethics can add to the idea of principlism that acting in a moral way is more than learning how to make a balance between several moral principles. Virtue ethics can teach clinicians that ethics is more than just a matter of knowing and following a given set of rules or norms. Of course, we need clinicians to be aware of their deontology but things do not stop there. The added value of a virtue ethics training is that it demonstrates that in the end, ethics comes down to acting by persons in a medical relationships.[39]

Among the major topics in virtue ethics in medical education, according to a recent scoping review article of Doukas et al.,[40] are altruism, development of virtuous traits, care as virtue, role modelling, humanistic behaviour, virtues as principles, the hidden curriculum and physician–patient relationship. Those topics ought to be included in the formal training curriculum. At the end of the training programmes, students should understand the meaning and importance of virtues, become virtue literate and have opportunities to develop their moral character during medical training.[33,p. 31]

There are various approaches for an introduction of virtue ethics into the early medical education. One approach is proposed by Pellegrino and Thomasma[4] in their final chapter of '*For the Patient's Good*', Chapter 15, on 'Beneficence-in-Trust: How it is applied'. Here, the subject is how promoting the 'patient's good' best is realized within concrete clinical situations. They use an unorthodox angle, namely looking at the process of ethical and legal deliberations in landmark medical–legal cases, such as the Quinlan case, the

Saikewicz case, the Nejdl and Barber case, the Bartling case, the Brophy case, the Jobes case, the Bouvia case and the Corbett versus D'Alesandro case. An essential point to take from these case-descriptions is that they illustrate the frictions and contradictions in value focus when the communication between physicians, patients and/or families has broken down.

Frey[4,14,15] too discusses how virtues can be developed in training programmes. She stresses that study of how different moral role models have faced and responded to morally difficult situations can stimulate students to follow virtuous actions. Moreover, trainees should be encouraged to write their own codes of conduct and to compare them with existing standards. According to Frey,[15] a virtue ethics perspective justifies a focus on concrete cases instead of abstract decision-making, and role playing, where a person practises the skills necessary for moral virtue; finally, the implementation of virtue in the actual delivery of healthcare, something that requires capable guidance is warranted. This leads us to the next step.

2. As a second step, at the hospital department or clinic, senior healthcare team members ought to provide interns and residents with a toolbox for resolving ethical dilemmas they encounter in their day-to-day work. Throughout role modelling, seen through using value-laden questions such as 'what the patient's best interest is in a particular case and how it relates to a physician's responsibility and integrity'. Then, it may be possible and fruitful to link the personal views and experiences with the principle-based approaches. In such a way of training in virtue ethics the 'hidden curricula'[41] will become more explicit, by discussing it openly with colleagues and giving residents feedback regarding its application.

Informal training should include routine deliberation meetings at the department and at the institutional level. Here, the involvement of the institutional ethics committee will provide additional value in expanding the depth in those discussions. Acquainting practitioners to the activity of the ethics committee may encourage them to turn to it for assistance once they encounter difficult cases requiring difficult ethical decision-making. If an ethics committee is less accessible, a 'three wise men' function, which is common in British hospitals, or the Dying Patient Act Committee in Israeli hospitals[3] is an alternative.

3. On the institutional level, it is important to create and publicize guideline documents to clarify the mutual relationships between virtues and rules. Those guidelines are more than replication of the relevant statutes and national guidelines, as it should be specific to the institution. In particular, guideline documents must address what is expected of a physician in terms of striving to become a virtuous professional, on top of what is expected in terms of compliance with rules. A multidisciplinary team of medical educators and ethicists who are skilled and experienced in resolving ethical dilemmas and assisting team members facing moral distress should be responsible for the creation and implementation of these guidelines.

4. Finally, assessment and evaluation of the training programme of students and residents is required. The evaluation process will focus on the development of moral character by continuous virtue ethics training. For that purpose, medical ethicists and educators should develop a valid, reliable and fair means for assessment.[36] The teaching and assessment tools suitable for that purpose are beyond the scope of this paper. However, case-based dilemmas are a promising approach. As ethics education is an ongoing process, which does not end at the Medical School but rather continues throughout the professional career,[33,p. 30] evaluation and assessment of moral character of students, residents and practicing physicians later on in their career could and ought to be monitored and assessed throughout the professional development.

5 | CONCLUSION

In recent years, the therapeutic relationship has been met by obstacles such as mistrust on the patient end, and burnout, compassion fatigue and moral distress on the physicians' end. The unique circumstances of the pandemic worsened those difficulties. At the same time, at least for a while, there was a surprising increase in public trust and appreciation of the medical profession. Bellazzi and Boyneburgk[7] recently stated that the COVID-19 calls for virtue ethics. As explained in the opening section of this paper, strengthening Virtue Ethics education and practice among health care professionals can be instrumental in closing the gap between the medical profession and the public, as its values apparently could assist during the exceptional circumstances into which the pandemic has put health care professionals.

For that purpose, it is a challenge to design and implement moral training curriculum and develop effective tools for realizing a practice based on the shared values behind this period of mutual appreciation between public and profession. In particular, Virtue Ethics training might be an answer to realize that newly found 'common good'.

Applying the four-step model at the least may contribute to a decrease in moral distress of physicians.[42] This, in turn, may contribute to better health outcomes for patients. Better said in the words of a fourth-year resident in a COVID-19 ICU Department in New York: 'My natural physician's instinct before COVID-19 was to help families navigate through the objective data: Po_2, cardiac status and blood pressure. During my time in the COVID-19 ICU, I focused less on ventilator settings and more on the overall comfort level of my patients when updating their families. For myself and for my colleagues, these daily phone updates became a particularly sacred part of the day, when we could relay information and prognoses and, most importantly, make human connections, despite the hecticness of the ICU'.[43]

Finally, we want to stress the need for changes at the level of institutions and practices in society. As MacIntyre[44] has stated, society or community needs to facilitate the circumstances needed to hold people together with moral practices and the common good. It is only through communities and shared practices that virtue ethics is attainable. When the social conditions and training are both in place, then people can enact the virtues through the exercise of phronesis and achieve a eudaimon life (the good life).

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article, as no data sets were generated or analysed during the current study.

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