# The Healing Factor of Virtue in Medicine

*Why physicians should apply virtue ethics to best fulfill their professional role*

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"Medicine is a moral enterprise. And if you take away the ethical and moral dimensions, you end up with a technique. The reason it's a profession is that it's dedicated to something other than its own self interests."[1]

Edmund Pellegrino

[1] Pongsajapan, R. (2013, June 18). *Bioethics Founder, Georgetown Professor Pellegrino Passes Away*. Georgetown University. https://www.georgetown.edu/news/bioethics-founder-georgetown-professor-pellegrino-passes-away/, accessed on 18-06-2021.

## Abstract

In the current health care systems the focus seems to be less and less on the moral aspect. The current dominant biomedical model of medicine holds that diseases should be defined according to the abnormal microphysiological parts and processes that constitute diseases, and that microphysiological processes are the object of medical intervention. This, together with the shift in medicine from general care to specialist care, the large-scale character of medicine, bureaucratic demands and technologicalization, is resulting in the depersonalisation of the medical profession. In this thesis, the trend towards depersonalisation is considered a problem because it obfuscates the strongly moral dimension of the doctor-patient relationship, which should be central to the practice of medicine. Morality is referred to as a healing factor in medicine. This doctor-patient relationship has become the subject of a debate because it has come under pressure due to the aforementioned depersonalisation. The technological model has become so dominant that we need a renewed focus on the personal dimension of medicine. The aim of this thesis is to demonstrate that virtue ethics in the Aristotelian tradition can promote the personal and moral aspect within medicine, and that this especially contributes to the patient's healing process as well as the physician's well-being.

Keywords: medical ethics, Aristotelian virtue ethics, morality, biomedical model of medicine, healing process, doctor-patient relationship

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## Introduction

With his famous painting "Science and Charity" (1897), as shown on this thesis' cover page, Pablo Picasso depicts his sister's deathbed. The period in which he made this painting is characterized by great medical progress, in which the cure of diseases became more central.[2] Nowadays, medicine's most important aims are still to cure and heal. According to the biomedical model of medicine, this healing is aimed at abnormalities of the physical body. However, there is an emerging debate about the doctor-patient relationship, and thereby, an increasing awareness about the fact that the patient should not only be seen as a physical body, but also as a person with a character, beliefs, desires and fears.[3] This personal aspect often seems to be forgotten and the focus of medicine appears to have become scientific and objective. I can clearly see this dichotomy in Picasso's painting: on one side of the bed sits the doctor who symbolizes science, and on the other side a nun who symbolizes charity. Some philosophers, like Edmund Pellegrino, argue that when we reduce the moral aspect to principles and rules, medicine is nothing more than a technique and the patient will be reduced from a human being to a physical body.[4] I consider this depersonalisation and reductionism problematic, and will argue that a human being needs to be considered as a whole person in order to heal properly. With that aim in mind a physician needs to display a certain degree of humanity in her relationship with her patients. This is essential because care and attention for the patient can enhance the physical healing process.[5] When the patient is able to trust the physician, this can have a positive effect on the patient's mind, and consequently, the patient's body. To serve this purpose, I will argue that virtue ethics in the Aristotelian tradition can help bring back this essential part of the doctor-patient relationship. We have to ask ourselves "what kind of person should a doctor be?" instead of "what rules should a doctor follow?". By advocating for a place for virtue ethics in medicine I do not reject rules and protocols: I will argue for a medicine based on virtue ethics, where rules and laws aim to stimulate the virtues of the physician.

This thesis is divided into four chapters. Chapter 1 provides a short historical overview of medicine. In chapter 2, I will describe the current role of virtue ethics in medicine: I

[2] During ancient times the aim of medicine was also about curing diseases, but with the focus on the self-healing ability of the body. Until circa 1880 medicine was characterized by auto diagnosis, self-medication, and neighborly help. The medical intervention was based on the elements and humours theory ascribed to Hippocrates. From about 1880, the mode of medical intervention changed: the cure of disease became more central because of the expanding possibilities in clinical research, pathology anatomy, microbiology, and technology. I will further elaborate on this in the next chapter.

[3] Cf. the debate between reductionism vs. holism in medicine.

[4] For further reading about Edmund Pellegrino's & David Thomasma's view on technology and morality within medicine see Pellegrino & Thomasma (1993): 37-43, 105, 122-125. For James Drane's view see Drane (1995): 69.

[5] van Os, T. W., van den Brink, R. H., Tiemens, B. G., Jenner, J. A., van der Meer, K., & Ormel, J. (2005). Communicative skills of general practitioners augment the effectiveness of guideline-based depression treatment. *Journal of Affective Disorders*, *84*(1), 43–51. https://doi.org/10.1016/j.jad.2004.09.005

will briefly describe what virtue ethics is, and correspondingly, what it means to be a virtuous doctor. In chapter 3, I will argue *why* doctors should use virtue ethics to best fulfill their professional role, based on five arguments:

1. Medicine is a moral activity in itself
2. The biomedical model, and its attitude towards the patient, falls short
3. Virtue ethics also supports the doctor's well-being
4. Virtue ethics can help to restore a climate of trust in contemporary health care institutions.
5. Medical ethics cannot be based on rules and principles

To substantiate my views, I will cite two particular philosophers' works. One is James Drane's *Becoming a Good Doctor* (1995), and the other is Edmund Pellegrino and David Thomasma's *The Virtues in Medical Practice* (1993). They have contributed to this specific topic extensively. However, my aim is not only to demonstrate how virtue ethics in medicine can make a difference in moral situations and analyses, but also that virtue ethics can enhance the patients' physical healing process. I will do this by citing various scientific studies. In chapter 4, I will outline which virtues a physician must possess. Some of them were already put forward as useful for medical practice by Drane and Pellegrino & Thomasma, and I will add two more that are of primary importance for the specific purposes of promoting the patient's healing process and protecting the doctor's well-being.

## 1. The shift in emphasis from patient to disease

Before I will describe the current place of ethics in medicine, I will give a short historical description of medicine. Hippocrates (c. 460 – c. 370 BC), also known as the father of medicine, was born on the island of Kos, where he founded a famous medical school. Hippocrates taught his students to always consider the patient as a fellow human being and to treat him or her accordingly. Moreover, according to Hippocrates, the doctor ought to treat sick people, and not just diseases.[6]

In recent years, however, advances in science have led to a relative overvaluation of the physical, medical-technical aspect of Western medicine.[7] This is also termed the *biomedical revolution*. From the period around 1880, which Edward Shorter refers to as the 'modern period', the physician gained a lot of authority.[8] This changed from about 1950 when there was an ever-growing estrangement between doctor and patient.[9] From this period until the early twenty-first century, a shift took place that consisted of an emphasis from "the sick person" to "sickness". The patient's needs no longer counted as the highest law, as we saw in the Hippocratic tradition, which Shorter referred to as the 'traditional period'.[10] Nowadays, Western medicine seems to revolve around the mere treating of diseases and thereby the personal aspect of medicine has faded into the background of the physician's mind. This new paradigm contradicts the old transferred values of the continuous availability of the physician and his or her attention.[11] This currently dominant model in medicine is called the *biomedical model*, which originates from Rudolf Virchow's conclusion that all disease results from cellular abnormalities.[12] The biomedical model is often associated with medical reductionism and contrasts with medical holism. Jacob Stegenga defines medical reductionism as follows: "Medical reductionism holds that diseases should be understood in the finest-grained way possible, by defining diseases according to the abnormal microphysiological parts and processes that constitute diseases, and that medical interventions should target those microphysiological parts and processes."[13] Holistic views on medicine, instead, recognise that psychological and social factors also influence a patient's well-being and health.[14]

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[6] Porter, R. (1997). *The Greatest Benefit To Mankind: A Medical History of Humanity*. W. W. Norton & Company, p. 56.

[7] Wal, K., Verbrugh, H. S., Feenstra, L., & van der Wal, K. (2017). *Denken over geneeskunde*. Driehoek B.V., Uitgeverij De, p. 193.

[8] Shorter, E. (1986). *Bedside Manners: The Troubled History of Doctors & Patients* (1st UK edition). Viking, p. 75.

[9] Shorter, *Bedside Manners: The Troubled History of Doctors & Patients*, p. 179.

[10] Given space limitations, a complete overview of the development of Western medicine can be found in Shorter (1986).

[11] Wal, Verbrugh, Feenstra, & van der Wal, *Denken over geneeskunde*, p. 180.

[12] Wade, D. T., & Halligan, P. W. (2004). Do biomedical models of illness make for good healthcare systems? *BMJ*, *329*(7479), 1398–1401.

[13] Stegenga, J. (2018). *Care and Cure*. Amsterdam University Press, p. 67.

[14] A modern work on holism about disease is Michael Marmot's Status Syndrome, in which he argues that health and longevity are intimately related to position in the social hierarchy. The lower the status, he

Hippocrates already acknowledged this by arguing that doctors should consider the patient's environment and way of living.[15]

By embracing the biomedical model and its reductionism of disease to mere "abnormalities in the body", the focus on the moral dimension of disease fades into the background. Because of the fact that a disease can be caused by multiple factors, at multiple levels, and working together in complex ways, the healing process also consists of more than just healing a physical body with abnormalities. Obviously, medical intervention is an indispensable part of healing, but the mental and moral aspects also play an important role. It is precisely this insight that a physician needs to have to best serve the purpose of medicine. This implies that the doctor's attitude towards the patient and the doctor-patient relationship need to change. A physician can no longer be someone who only cures abnormalities of a physical body, but needs to be someone who cares for the patient as a whole person as well. To be able to change this relationship between doctor and patient, we need a re-emphasis on virtue ethics.

states, the higher risk of illness and death, and consequently the shorter the life expectancy. See Marmot (2004): 150–154.

[15] Hippocrates. *Airs, waters and places*. Loeb classical library, vol. 147, p. 71-73.

## 2. The virtues in medical practice

### 2.1 Virtue ethics and its current place in medicine

Virtue ethics is an ethical theory that differs from Kantian ethics or consequentialism. Where deontology and consequentialism are focused on the question 'what should I do?', virtue ethics is concerned with the question 'what kind of person do I want to be, and how can I express that in my actions?' Virtue ethics is considered a broad theory on how you should live your whole life instead of solely on individual actions. Principle or rule-based ethical theories focus on the *actions* of a moral agent, and virtue ethics focuses on the *moral agent* himself who is performing the actions. Morality in the case of virtue ethics is a broad notion: it pertains both to interpersonal relations as to personal development.

There are several traditions within virtue ethics.[16] For this thesis, however, I focus on the Aristotelian tradition of virtue ethics. The notion of virtue finds its roots in the classical period, when Aristotle (c. 384 – c. 322 BC) wrote the *Nicomachean Ethics*, the *Eudemian Ethics*, and the *Magna Moralia*. For him, the development of virtuous character traits and thereby the attainment of human flourishing (*eudaimonia*) was the main goal (*telos*) of moral life.[17] According to Aristotle, a virtue can be defined as a good character trait, that should be intermediate between two other character traits, one of which is an excess and the other is a deficiency. The intermediate state is commonly known as the 'golden mean'. The two extremes can be called 'vices'. What is important is that we are praised for our virtues and reproved for our vices.[18] One can acquire virtues by habitual practice and training.[19] What makes virtue ethics special is that a virtuous person is expected to act virtuously, for the right reasons. In other words, a virtuous doctor will not act for the sake of duty or for personal advantage, but will act under a conception of what is morally right and worthy.[20] Towards the end of the nineteenth century, virtue ethics was connected to health care again and placed in the context of medicine. Unfortunately though, virtue ethics has been accused of failing to provide a foundation for medical ethics. Part of this criticism is that we cannot do without rules, because our society is too large and complex to leave health-related matters, especially urgent medical-ethical issues, to individuals and their individual actions.[21] I will take this into account and

[16] E.g., Stoic virtue ethics and Aristotelian virtue ethics from Ancient Greece (*Hellás)*. The Stoics focused on human nature more clearly than Aristotelian virtue ethics. Aristotle also worked with a concept of human nature and the virtues are seen as the perfecting of the rational soul of man. The difference between Aristotle and the Stoics is that the Stoics emphasize the concept of rational nature, ignoring all kinds of cultural and social aspects of human nature. For Aristotle, these aspects are important. A few examples of modern works on virtue ethics are Rosalind Hursthouse *On Virtue Ethics* (1999) and Alasdair MacIntyre's *After Virtue* (1981), in which they defend virtue ethics.

[17] Aristotle, Thomson, J. A. K., Tredennick, H., & Barnes, J. (2004). *The Nicomachean Ethics*. Penguin Books. Book I, chapter vii, 1097a26-b23.

[18] Aristotle, *The Nicomachean Ethics*, Book II, chapter v, 1105b30-1106a

[19] Aristotle, *The Nicomachean Ethics*, Book II, chapter i, 1103a14-1103b2

[20] Beauchamp, T. L., & Childress, J. F. (2012). *Principles of Biomedical Ethics* (7th Revised edition). Oxford University Press, p. 377.

[21] Graber, G. C., & Thomasma, D. M. H. P. D. C. (1989). *Theory and Practical Medical Ethics*. Van Haren Publishing, p. 151-172.

therefore I will not argue that we should entirely reject rules and principles in medical ethics. Virtues and rules can co-exist, considering virtue ethics as a foundation for medical ethics, where rules and policies supplement and stimulate the virtues. I will further elaborate on this in section 3.5.

Currently, medical students do get some courses on medical ethics or bioethics, but the emphasis is not on the development of their own moral character as a physician. Medical ethics is not a very popular topic among physicians, and studies have found medical students do not always feel like ethics classes apply to them.[22] Several students expressed frustration that ethics classes do not provide an answer to medical ethical dilemmas. A 4th year student commented: "I find it quite frustrating… Discussing questions in endless circles and never coming out with a firm resolution. I am a scientist and I like hard facts."[23] Moreover, medical ethicists are usually not doctors, but philosophers.[24] However, Aristotle often used medicine as an example for certain ethical situations. In his work *Ethica Nicomachea* for example, he writes: "[...] the agents are compelled at every step to think out for themselves what the circumstances demand, just as happens in the arts of medicine and navigation."[25] He argues that the excellence of human beings is a state of character which makes a person good and makes him perform his function well.[26] This implies we should also use virtue ethics in professional roles. In this thesis I argue that virtue ethics can indeed be useful within the medical profession. In *Principles of Biomedical Ethics*, Beauchamp and Childress wrote: "In professional life the traits that warrant encouragement and admiration often derive from role responsibilities. Certain virtues are essential to the discharge of these professional roles, and certain vices are intolerable in professional life."[27] In the following section I will give a more detailed description about what role virtue ethics can have in medicine and specify what makes a virtuous physician.

## 2.2 The virtuous doctor

Greek physician and philosopher Galen of Pergamon (September 129 – c. 210) wrote a lot about the close connection between philosophy and medicine. In his work *The Best Doctor is Also a Philosopher* he argued that an ideal physician needs to possess three types of skills: the mastering of logical procedures such as concept analysis and recognising inconsistencies, having insight into the ultimate constituents of the human body as subject to the same laws as nature in general, and the possession of moral virtues.[28] These skills are essential for conscientious dealing with patients and colleagues and for self-

[22] Johnston, C., & Haughton, P. (2007). Medical students' perceptions of their ethics teaching. *Journal of Medical Ethics*, *33*(7), 418–422. https://doi.org/10.1136/jme.2006.018010
[23] Johnston & Haughton, Medical students' perceptions of their ethics teaching.
[24] Drane, J. F. (1995). *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics* (Second ed.). Sheed & Ward, p. 6-7.
[25] Aristotle, *The Nicomachean Ethics*, Book II, chapter ii, 1104a7-10.
[26] Aristotle, *The Nicomachean Ethics*, Book II, chapter vi, 1106a21-24.
[27] Beauchamp & Childress, *Principles of Biomedical Ethics*, p. 32.
[28] Assmann, F. W., G., & Omnia, G. O. (2016). *Hapanta. Opera omnia. Editionem curavit Carolus Gottlob Kühn; v.18 pt.02 (Greek Edition)*. Wentworth Press, p. 59-61.

discipline and integrity in medical practice.[29] In line with this I will argue that to fulfill the goal of medicine, a virtuous doctor must possess two sorts of competences: technical competence and moral competence.

As we have seen, according to medical reductionists, technical competence will be sufficient to be able to heal most diseases. However, Aristotle already separated technical from moral competence.[30] Technical competence and living virtuously, Aristotle holds, are two different things. He argues that philosophical wisdom and practical insight are both necessary and preferable in themselves, for they are forms of optimal functioning, each of a different part of the soul.[31] Thus, ensuring the healing process should also be about the patient's mental well-being, not *only* about the patients' physical state. Drane writes:

> "One of the dangers to which the modern physician is exposed is to lose sight of this when the being of the patient is reduced to a number in a long line or a complex of purely physical responses. Once the doctor thinks of himself [...] as an engineer working on a piece of machinery rather than in a relationship with other persons, the ground of respect is lost. Just because the engineering model is so powerful in this age of technological medicine, an emphasis is needed on the patient as a person. Effort is required by the doctor to develop the virtue of respect precisely because the medical environment today tends to form the doctor in the opposite direction. And yet, without reverence and respect, a technically accomplished physician cannot be a good doctor." [32]

In other words, technical competence is not sufficient as a definition of virtuousness: righteousness and morality are also conditional for healthcare professionalism. Obviously, technical competency is an indispensable requirement for a doctor that should not be forgotten: the doctor must continuously work on his or her technical competence and this can, perhaps, also be regarded as virtuous behaviour, because feeling responsibility to always be at your best shows one's commitment. This relates to so-called 'epistemic virtues' like being well-informed, objective or truth-loving.[33] However, a disclaimer must be made: in certain cases such as emergency operations, virtuous behaviour will obviously not be prioritized over technical competence, or will not even be necessary at all.[34] In most cases, though, developing a good doctor-patient relationship is required. On this topic Pellegrino & Thomasma write: "At times, technical competence

[29] Tieleman, T. (2016). De beste dokter is ook filosoof. Uitgesproken bij de aanvaarding van de leeropdracht Antieke Filosofie en Geneeskunde op 22 januari, Utrecht, Nederland, p. 17.
[30] By doing so, he rejected the Socratic idea of an 'art of life', which later made a powerful comeback due to the emergence of Stoicism. For further reading about the 'art of life' see Tieleman, T.L.. (2008). The Art of Life. An Ancient Idea and its Survival. SCHOLE. 2, 245-252.
[31] Aristotle, *The Nicomachean Ethics*, Book VI, chapter xii, 1144a2.
[32] Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, p. 69.
[33] Some of these epistemic virtues have been set out by Massimo Piglucci (2017).
[34] This is why, when I mention the term "doctor" or "physician", I mostly refer to medical professionals who can enter into a relationship with their patients, such as specialists or general practitioners.

must be predominant - that is, when the patient is under anesthesia and the surgeon is anastomosing coronary vessels. But preoperatively and postoperatively, the personal and emotional sharing of the experience takes precedence. At every point in a medical relationship, compassion and competence go hand in hand as necessary and mutually reinforcing virtues essential to attainment of the ends and purposes of the clinical encounter."[35]

Thus, a patient needs a doctor that is technically competent and possesses adequate medical knowledge, of which we can only hope he or she will use it in the patient's interest. To apply this competence and knowledge in the patients' best interest, a doctor needs to be virtuous.

[35] Pellegrino, E. D., Thomasma, D. C., & Oxford University Press. (1993). *The Virtues in Medical Practice*. Oxford University Press, p. 83.

# 3. Why doctors should use virtue ethics

After having demonstrated what a virtuous doctor *is*, we have to take a closer look at this and answer the question *why* the patient needs a virtuous doctor. In this chapter I will clarify why doctors need to use virtue ethics to best fulfill their professional role, on the basis of five arguments.

## 3.1 Medicine as a moral activity

Pellegrino & Thomasma have listed certain characteristics of relationships that are developed in professions such as the legal profession and health care providers. They mention the dependence, vulnerability, inherent inequality, the fiduciary character and most importantly the fact that the professional is a member of a moral community. My first argument concerns this nature of the medical profession and demonstrates the importance of the doctor-patient relationship. It holds that medicine is a moral activity in itself, precisely because of the special relationship between doctor and patient.

This moral aspect is indispensable to the doctor-patient relationship, because the patient is vulnerable and could fear loss of control over his or her own body. Moreover, the physician possesses knowledge the patient does not possess. Drane also emphasizes these aspects of the relationship between doctor and patient. He writes: "what the doctor does for the sick person involves, by definition, a certain closeness or relationship."[36] In other words, the fact that the patient is vulnerable, means that a doctor has a certain position of power. Therefore, it is important for the physician to possess certain virtues, such as trustworthiness and integrity, to be able to handle this professional position well. A rights-based or obligation-based ethics is not enough to create an environment of trust, precisely because these are often meant to deal with situations of (mutual) distrust. Pellegrino & Thomasma argue about the doctor-patient relationship: "their reality and irreducibility provide the most powerful argument for the restoration of virtue ethics in professional morality".[37] In short, the thing that makes the medical profession special is the fact that people will come to a lawyer or doctor because they seek their help. In this relationship, the patient is vulnerable, which makes it crucial that the client or patient can trust the person who is in front of them. Virtue ethics can help the physician be a trustworthy person.

## 3.2 The shortcomings of the biomedical model

As we saw, the biomedical model of medicine conceives disease in terms of microphysiological abnormalities. Consequently, health is the absence of these abnormalities. Intervention, according to this model, is to correct the imperfections of the body. Obviously, in many cases this can be considered an effective way of curing certain diseases and cure is a very important aim of medicine. However, when we reduce disease

[36] Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics,* p. 21.
[37] Pellegrino & Thomasma, *The Virtues in Medical Practice*, p. 155.

to physical abnormalities, we omit the moral aspect and the communicative aspect of disease and health. This consequently reduces medicine to a technique, rather than a profession. And, in order to heal properly, a human being has to be treated as a whole person, and not just as a physical body. I argue for this holistic principle because the healing process is not solely based on medical intervention: moral and mental matters are also part of it. A virtuous doctor is able to create a good relationship with the patient, which is crucial for the healing process. In other words, a morally good doctor is the first drug that can be prescribed when a patient enters the consultation room. According to Drane, the way illness is experienced by patients and the needs it creates in them, serves as the objective guide for a good doctor's character development.[38] Therefore, the doctor-patient relationship should contain a certain "degree of humanity".

This humaneness in the doctor-patient relationship can consist of good communication, being able to rely on the doctor or receiving mental support from the doctor. For example, a doctor can provide mental support by being involved or being empathetic (the virtues related to this would be "Engagement" and "Compassion"). These virtues lead to better health care for a couple of reasons. First, they make diagnoses easier and more efficient. As mentioned in section 2.2, a physician must possess both technical competence and moral competence. Technology and effectiveness are not all that matters; morality is also important to ensure the healing process. However, morality is not entirely separate from effectiveness. Being involved in a patient's life is effective because good communication ensures that diagnosis is made easier and fewer (unnecessary) referrals to other specialists are made.[39] On this topic, Drane also noted: "Doctors who do not talk to patients or do not talk enough, leave the patients with all sorts of mistaken notions; the diagnostic process is left incomplete and therapeutic effectiveness is curtailed."[40] Second, it makes the patient feel "seen" which can contribute to enhancing the healing process. Third, it leads to fewer burnouts among doctors. This brings me to my next argument.

### 3.3 Virtue ethics and the well-being of doctors

The biomedical model of medicine can be called a disease-centered medicine, whose purpose is to "cure". In contrast to this, a patient-centered medicine focuses on the patient, and the physician's job is to engage with the patient, to develop an understanding of the entire life of the patient, to focus on overall health promotion and to establish a mutually respectful relationship. Critics of this patient-centered view argue that it is an inefficient use of limited resources: especially the physician's time.[41] This is one of the most important reasons why physicians, healthcare insurance companies and employers prefer the biomedical model in medicine. Attention to, and intervention in complex psychosocial problems takes a lot of patience and a lot of time, and thus costs more

[38] Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics,* p. 20.
[39] Epstein A.M., & Street Jr R.L. (2007). *Patient-centred communication in cancer care: Promoting healing and reducing suffering*. Bethesda, MD: National Cancer Institute.
[40] Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, p. 49.
[41] Stegenga, *Care and Cure*, p. 77.

money. In addition, when a physician deals with the psychosocial aspects of the patient's problems, he or she becomes much more involved with the patient as a person. There is an actual person in front of the doctor, with whom contact must be made, and for whom a personal protocol must be established.[42]

So we might wonder who will benefit most if virtue ethics were to play a greater role in medicine. One could say that if we expect doctor's to focus on so many aspects at the same time, we risk disregarding the well-being of the doctor.[43] As we have seen, the possession of virtues by the physician is indispensable, mainly for the protection of patients and for their healing process. However, the practice of virtue ethics is also conducive towards the well-being of doctors themselves. They often run the risk of being criticized, or even being sued, for having done too much or too little. For example, poor communication is at number 2 in the top 3 of complaints against doctors.[44] The practice of virtue ethics helps them make more rationally and emotionally balanced choices. Through gaining this experience, the physician will become increasingly good at being empathetic, while at the same time retaining her composure in the face of the patient's emotions. Possessing a virtue like Compassion helps physicians to keep this right balance and to avoid overburdening themselves. I will further explain this in section 4.3.

### 3.4 The erosion of trust

This fourth argument concerns the relation of trust between patients and physicians. According to Beauchamp and Childress, trust is a confident belief in and reliance on the moral character and competence of another person, often a person with whom one has an intimate or established relationship.[45] A climate of trust is endangered in contemporary health care institutions, as is evidenced by the number of medical malpractice suits and adversarial relations between health care professionals and the public.[46] Physicians who have negative ways of communicating are more likely to be sued for malpractice than those with more positive doctor-patient relations.[47] Other causes of distrust of physicians, and the healthcare system as a whole, are mechanisms of managed care, like the increased use of specialists and the growth of large, impersonal, and bureaucratic medical institutions.[48] When bureaucracy becomes prevalent in medicine, it

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[42] Wal, Verbrugh, Feenstra, & van der Wal, *Denken over geneeskunde*, p. 188.

[43] I consider 'well-being' and' health' to be distinct concepts. Health is mostly considered the absence of disease, while well-being can be more than only the absence of disease. I consider well-being to be a normative concept. E.g., a person is doing well when they feel satisfied with their physical and mental state. There are several theories about what health and well-being are. For further reading on this topic see Stegenga (2018): 7-20.

[44] Reader, T. W., Gillespie, A., & Roberts, J. (2014). *Patient complaints in healthcare systems: a systematic review and coding taxonomy*. *BMJ Quality & Safety, 23*(8), 678–689. https://doi.org/10.1136/bmjqs-2013-002437

[45] Beauchamp & Childress, *Principles of Biomedical Ethics*, p. 39.

[46] Pellegrino & Thomasma, *The Virtues in Medical Practice*, p. 71.

[47] Moore, P. J. (2000). Medical malpractice: the effect of doctor-patient relations on medical patient perceptions and malpractice intentions. *Western Journal of Medicine*, *173*(4), 244–250. https://doi.org/10.1136/ewjm.173.4.244

[48] Pellegrino & Thomasma, *The Virtues in Medical Practice*, p. 71-77.

often leaves patients dissatisfied. Therefore, there is a strong need for physicians who are virtuous. In contemporary health care institutions we see a lot of rules and contracts. These rules are generally drawn up out of distrust, which again illustrates the desire for a physician who is trustworthy.[49] The physician is the one who must apply and interpret the rules and principles in the best possible way, and to do that he or she needs a good and trustworthy character. Aristotle reasoned that in intimate relationships "dealings with one another as good and trustworthy rather than 'bonds of justice' hold persons together".[50]

In addition to this, due to the erosion of trust in doctors, they seem to have less authority than they used to have. As we have seen in Shorter's work, from about 1950 there was an alienation between doctor and patient.[51] This has two causes. First, the focus during the medical training was on the preclinical subjects, which made communication subordinate to pathology. Second, due to the many medical breakthroughs such as within surgery, pharmacology, and technology, a new type of technological doctor was born. The focus on medical technology became so strong that the person behind the patient was neglected. As a result, patients are taking matters into their own hands and feel like they have to take charge of their own care. For example, they do their own research before visiting their physician, looking for a possible diagnosis, the optional treatments and the associated medicines. This, perhaps, can also be seen as an indicator of how little trust patients currently have in doctors or that they seek for a relationship of equality. I want to argue physicians can use virtue ethics to gain back some trust. In section 4.1 I will further elaborate on the specific Virtue of *Trustworthiness*, which I consider to be of primary importance for this purpose.

### 3.5 Virtue ethics versus rules and protocols

In his work *Bioethics: Methods, Theories, Domains* Marcus Düwell explains the current debate in bioethics between 'obligation-centered ethics' such as Kantian ethics, and virtue ethics. Düwell believes there is a lot of criticism of obligation-centred orientation of ethics these days with an appeal to virtue ethics.[52] Elizabeth Anscombe and Alasdair MacIntyre, for example, criticize the universalism of modern ethics, and attempt to achieve an alternative on the basis of Aristotelian tradition of virtue ethics. This criticism holds that the notion of a moral law would be a remnant of a form of morality based on the idea of a divine legislator, yet this legislator can no longer be given a systematic place.[53] On the other hand, Düwell writes that many advocates of these virtue-ethical expansions also develop universalistic notions without specifically arguing for the

[49] The fact that people desired a trustworthy physician was already acknowledged by the writing of the Hippocratic Oath around 275 CE and other deontological treatises.
[50] Aristotle. (1984). *Eudemian Ethics*, in The Complete Works of Aristotle, ed. Jonathan Barnes. Princeton, NJ: Princeton University Press. 1242b23-1243a13.
[51] Shorter, *Bedside Manners: The Troubled History of Doctors & Patients*, p. 179.
[52] Düwell, M. (2013). *Bioethics*. Routledge, p. 40.
[53] Anscombe, G. E. M. (1958). Modern Moral Philosophy. *Philosophy*, *33*(124), 1–19. https://doi.org/10.1017/s0031819100037943, p. 13.

validity of these universal demands.[54] Therefore, some philosophers believe, virtue ethics cannot provide a foundation in bioethics or medical ethics. In the light of this debate, Pellegrino & Thomasma have put emphasis on the fact that rules and laws are an *addition* to the virtues. They argue that virtue alone is not sufficient for all occasions in moral philosophy, since good dispositions or good character alone will not ensure that a moral act is good.[55] They write that a virtue-based ethic cannot replace principles and rules because experience demonstrates that not everyone has the same level of moral development, and rules are necessary to establish a minimum expectation of everyone.[56] It must be said, however, that virtue ethics in the Aristotelian tradition does not exclude rules, laws or principles. For Aristotle rules have two functions: rules are required because of the fact that most people are still more or less non-virtuous: rules keep them from acting badly and, more positively, rules stimulate them on the road toward virtue. For example, in considering the possible types of political organization, Aristotle argues that there can be one, few, or many rulers, and that their forms of rule and legislation should be in the common interest.[57] In other words, the goal of an organized city-state (*polis)* is to promote human flourishing (*eudaimonia*), and not something to be pursued for its own sake.

I want to argue that when a rule and a virtue are in conflict, virtue should be considered as a more important guide to action. Let us consider an example. Suppose that a physician has a duty to be honest about the patient's physical condition at all times, but at the same time the physician strives to acquire the Virtue of *Positivity*. Communicating the information in a detailed way will unnecessarily disrupt the patient's mental well-being, but withholding it conflicts with the duty to always be honest. In the end, I believe it is the moral agent who has to interpret rules, principles and duties in a virtuous manner and decide what is the best way to act in this situation. Moreover, gaining the trust of a patient cannot merely involve using the best technology or following a certain set of rules or duties. Virtue ethics also needs a place in medicine because rules and protocols will enable doctors to *do* good, but virtues enable them to *be* good: to be a noble and trustworthy doctor in addition to being a technically competent doctor.[58] Being technically competent and striving to do better can nevertheless also be considered an epistemic virtue.

I will give two reasons why medical ethics based on rules or principles and protocols is not sufficient. First, the problem of rules and principles is they might not apply to every situation. For example, imagine a doctor needs to deliver someone bad news. There are recommended ways of and guides on how to deliver bad news[59], but

[54] Düwell, *Bioethics*, p. 42.
[55] Pellegrino & Thomasma, *The Virtues in Medical Practice*, p. 21.
[56] Pellegrino & Thomasma, *The Virtues in Medical Practice*, p. 27.
[57] Aristotle, & Rackham, H. (1944). *Politics* (Ser. Loeb classical library, 264). Harvard University Press, 1279a26–31.
[58] Pellegrino & Thomasma, *The Virtues in Medical Practice*, p. 173.
[59] Rosenzweig, M. Q. (2012). Breaking bad news. *The Nurse Practitioner*, *37*(2), 1–4. https://doi.org/10.1097/01.npr.0000408626.24599.9e

solely possessing that knowledge is not necessarily sufficient because the doctor is the one who must be able to properly apply and interpret these guidelines in each specific situation. Virtue ethics, instead, enables the physician to react appropriately to every specific situation which requires a specific virtue, like empathy or compassion. Second, virtue ethics ensures that the physician is intrinsically motivated to perform virtuous actions. This relates to the debate about internal versus external reasons.[60] Recent studies have shown that the quality of experience and performance can be very different when one is behaving for intrinsic versus extrinsic reasons for action.[61] Following rules and protocols does not necessarily come from intrinsic motivation to do the right thing, therefore they more easily invite violation. Virtues, instead, keep the doctor on his or her route to their ideal of being a good doctor, because a virtuous person is expected to act virtuously, for the right reasons (i.e., a virtuous doctor will not act merely for the sake of the rule or for personal advantage, but will act under a conception of what is morally right and worthy).[62] Beauchamp and Childress write: "Many human relationships in health care involve persons who are vulnerable, dependent, ill, and frail. Feeling for and being immersed in the other person are vital aspects of a moral relationship with them. A rights-based or obligation-based account may neglect appropriate forms of empathy because of its focus on protecting persons from wrongdoing by others."[63]

In short, by arguing that virtue ethics should be fundamental in medicine, I do not entirely reject rules, duties and protocols. In fact, rules and protocols cannot be dispensed with, because of the large-scale nature of current Western medicine. Vice versa, a medical ethics based on rules, duties or principles does not by definition exclude the virtues. Thus, by focusing on the Aristotelian tradition in virtue ethics, I consider rules and laws to promote the acquisition of the virtues of the physician.

[60] For further reading see e.g., Williams' Internal Reason Theory, in Williams, B. (1979). Internal and External Reasons. Reprinted in Moral Luck, Cambridge: Cambridge University Press, 1981.
[61] Ryan, R. M., & Deci, E. L. (2000). Intrinsic and Extrinsic Motivations: Classic Definitions and New Directions. *Contemporary Educational Psychology*, *25*(1), 54–67. https://doi.org/10.1006/ceps.1999.1020
[62] Beauchamp & Childress, *Principles of Biomedical Ethics*, p. 377.
[63] Beauchamp & Childress, *Principles of Biomedical Ethics,* p. 36.

## 4. Indispensable virtues

"The man, therefore, who is found to be a true physician must be a friend of moderation, just as he must be a companion of truth."[64]
– Galen of Pergamon, *That the Best Physician Is Also a Philosopher*

In this chapter I will explain which moral virtues are indispensable within medical practice. Drane and Pellegrino & Thomasma also both gave an overview of the virtues they believe a physician should possess.[65] However, some of the virtues they mentioned I left out of the list I will present here. Not because I don't consider them important or relevant, but because I want to show how virtue ethics can serve the patients' healing process and for that specific purpose some of the virtues mentioned are less important. Like mentioned above, epistemic virtues are also considered relevant in this regard, but my focus is on moral virtues. All the included virtues serve the purpose of enhancing the healing process, and are in one way or another, interrelated. The Virtues of *Compassion, Respectfulness* and *Truthfulness* are relevant virtues mentioned by Pellegrino & Thomasma and Drane. I will also propose two virtues in addition which are not yet mentioned by them or in other applicable literature: the Virtue of *Engagement* and the Virtue of *Positivity*. A physician needs to possess the virtues mentioned above for two reasons: first, they are in service of the physical healing process. Second, they enhance the well-being of both the patient and the physician. The former attributes an instrumental function to the virtues. The latter attributes a fundamental function to the virtues, as we see in Aristotle. He does not make this clear distinction, but considers the virtues to be both the means to and the components of the end of human flourishing. James Drane and Pellegrino & Thomasma take different approaches between themselves, which in some ways do, and in some ways do not, correspond with mine. Drane considers the structure of the doctor-patient relationship as an objective ground for good character traits which make for a good doctor. The different dimensions of this relationship constitute separate foundations for different but related virtues.[66] For Pellegrino & Thomasma this is teleological, relating the medical virtues as a practice to the ends of medicine.[67]

### 4.1 Trustworthiness

The erosion of trust mentioned in chapter 3.4, shows the strong need for trustworthy physicians. I consider it to be of primary importance to bring back a climate of trust, because being able to trust our physician has multiple advantages. First, it is desirable for

[64] Assmann & Omnia, *Hapanta. Opera omnia. Editionem curavit Carolus Gottlob Kühn*, p. 59.
[65] Drane's list contains the following virtues: Benevolence, Truthfulness, Respect, Friendliness, Justice, and Religion. Pellegrino and Thomasma's list contains the following virtues, some of which are the same as Drane's and others different: Fidelity to Trust, Compassion, Phronesis, Justice, Fortitude, Temperance, Integrity, and Self-Effacement.
[66] Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics,* p. 46.
[67] Pellegrino & Thomasma, *The Virtues in Medical Practice*, p. xiii.

the physician to acquire the Virtue of Trustworthiness, because this will give a physician more freedom to act and be less bound to rules and principles. As I have demonstrated in chapter 3.5, medical ethics based solely on rules and protocols is generally undesirable. Moreover, protocols or rules that physicians must follow, are generally considered to arise from an ethics of distrust.[68] Being able to trust physicians gives us less need for these rules and contracts.

Second, as we have seen, we know that our docent will be intrinsically motivated to do the right thing for the right reasons. According to Drane virtue has the added advantage of fostering good acts even when no one is watching or reviewing or regulating.[69]

Third, Trustworthiness of the physician has the practical outcome of making health care effective.[70] When we trust a physician, we have more confidence in a successful recovery. On this topic, Pellegrino & Thomasma write: “Perhaps most serious of all, an ethics of distrust compromises the chance of achieving the purpose of professional relationships.” In this case, the purpose of the medical profession is obviously healing. They continue: “Can the sick person be healed -made whole again- when he is suspicious of the motives and the methods of the healer?” This demonstrates that it is essential for the patient’s healing process to trust the physician, because it can have a positive effect on the patient’s mind, and consequently, the patient’s body. This ties in with my next point on the importance of the Virtue of Positivity.

## 4.2 Positivity

The Virtue of Positivity can be considered indispensable for the aim of ensuring the patient’s healing process. There is a strong correlation between the way a doctor communicates and how a patient responds to that, both mentally and physically.[71] This phenomenon is commonly referred to as the "placebo effect".[72] Recently there has been renewed attention in scientific circles for the placebo effect. The intention of the research done was to better understand the mechanisms behind the placebo effect, hoping this knowledge could possibly benefit medical care. By referring to the placebo-effect, I limit myself to say something about the extra beneficial effects, related to factors in the doctor-patient relationship and to the communication between doctor and patient. This is considered an addition to the actual biomedical treatment. The aim of practicing the

[68] Pellegrino & Thomasma, *The Virtues in Medical Practice*, p. 71.
[69] Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, p. 18.
[70] Beauchamp, & Childress, *Principles of Biomedical Ethics*, p. 39.
[71] Verheul, W., & Bensing, J. M. (2008). *Het placebo-effect in de huisartsenpraktijk: communicatie als medicijn*. Bijblijven, *24*(2), 38-44, https://doi.org/10.1007/bf03076330, p. 42.
[72] It is important to clarify the difference between the terms "placebo" and "placebo effect". Any medical intervention without specific efficacy is in fact a placebo. The "placebo effect" is the health effect that patients experience as a result of a treatment that in itself has no known healing effect, but nevertheless a positive effect. This mainly concerns the way in which and the conditions under which the treatment is applied, and factors in the relationship between doctor and patient. In short, it is about the effect of the psychological, social and cultural context of the treatment, which evoke confidence or hope. See Verheul & Bensing (2008).

Virtue of Positivity is to influence the creation of expectations and the reduction of (unnecessary) stress or negative feelings. Whether a diagnosis is communicated in a positive or negative way, can make a difference in how sick the patient *feels* and how the patient experiences the illness or disease versus how sick someone actually is *physically*. Empirical evidence indicates that multiple mechanisms come into play here, for example when the physician creates expectations in a warm, confidence-inspiring way or when patients become aware of how they have been conditioned by certain healthcare experiences in the past.[73]

However, the influence on the patient's expectations by the physician also raises ethical dilemmas.[74] Can you give patients unfounded optimistic information about the prescribed treatment if you think it will make them feel better? Or might it be, in turn, morally reprehensible *not* to use the power of the placebo effect in this way? Anyhow, I believe a physician should not give 'false hope'. This relates to the Virtue of Truthfulness Drane has put forward in his work. He writes:

> "Rather than worrying about whether the truth will hurt the patient, doctors often frightfully worry whether or not what they know is the truth. Is the medical information certain enough to warrant being communicated? [...] Not only are the variables beyond management, but "unscientific" influences like a positive or negative attitude can make all of the difference in a medical outcome."[75]

Thus, although this is a debatable topic that raises ethical dilemmas, it might be clear that the patient can certainly benefit from a doctor's positive attitude.

### 4.3 Compassion

The Virtue of Compassion is indispensable for both the patient's and the doctor's well-being for multiple reasons. First, when a patient goes to the hospital or to a general practitioner, he or she is in need of help and therefore dependent and vulnerable. In The Enigmatic Phenomenon of Loneliness, Karin Dahlberg wrote: "Not to be seen is painful in general. Not to be seen being a patient in need of care is especially painful."[76] In other words, the patient wants to be cared for and be heard. In order to care for a patient properly, a physician will need compassion for the patient and the patient's position.

Second, because virtue ethics strives for a character trait that is intermediate between two extremes, it will enable the physician to act in a balanced manner. Compassion allows physicians to find a balance between two problematic situations they could face: physicians tend to withdraw from the patient's plight on the one hand, and to over-involvement in the patient's life on the other hand. This is related to the fact that doctors have little time and often get burn-outs by wanting to do too much, or because

[73] Verheul & Bensing, *Het placebo-effect in de huisartsenpraktijk: communicatie als medicijn*, p. 40.
[74] Verheul & Bensing, *Het placebo-effect in de huisartsenpraktijk: communicatie als medicijn*, p. 41.
[75] Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, p. 60.
[76] Dahlberg, K. (2007). The enigmatic phenomenon of loneliness. *International Journal of Qualitative Studies on Health and Well-Being*, *2*(4), p. 202.

too much is expected of them. By acquiring the Virtue of Compassion physicians can protect themselves from being emotionally too involved or doing too much. The doctor's empathy towards the patient and a pleasant communication between doctor and patient also makes doctors themselves feel better: it leads to fewer burnouts.[77]

I am aware that the use of the mean in virtue ethics is solely seen in the tradition descending from Aristotle, and that most philosophers in this tradition do not even make use of it. This is because there has been quite a bit of criticism on the doctrine of the mean in Aristotle's work.[78] The criticism generally consists of two things. First, it holds that the doctrine is quite strong for it does not apply to all the virtues. Second, it holds that not all the virtues (need to) correspond to at least one vice, and that they certainly do not always hold the middle ground of two opposed vices.[79] For my purpose, however, the use of the mean has important advantages and I will still, with the criticism in mind, make use of it.

### 4.4 Engagement

Another key virtue, which seems to have received no explicit mention, let alone treatment, in previous literature, is that of Engagement. A physician needs to acquire it for two main reasons. First, to determine what each specific patient needs in order to heal. Second, to make diagnosis easier.

The biomedical model is aimed at helping as many people as possible on a large scale. This is obviously a positive aspect of the current biomedical of medicine, but can also be problematic. The patient is treated based on a protocol that is applied to every other patient, while not every patient is the same or needs the same treatment in order to recover properly. Imagine, for example, Patient A will visit his physician looking for a quick solution for his sleeping problems. The doctor responds by immediately proposing to prescribe sleeping pills. Patient A takes the doctor's advice, but actually does not know taking this medication can make you feel sleepy and drowsy during the daytime. The physician had not asked about Patient A's living- or job situation and therefore does not know that he is actually a full time taxi driver. If the doctor had asked about the patient's habits he would have known that a quick fix like prescribing sleeping aids, might not have been the best solution for Patient A. In turn, some patients are best off with a "magic bullet" solution or a "quick fix" like this.[80] Therefore, a doctor needs to be engaged with the patient to determine what he or she needs. This could either be a good conversation

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[77] Krasner MS, Epstein RM, Beckman H, Suchman AL, Chapman B, Mooney CJ, et al. Association of an Educational Program in Mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians. JAMA. 2009;302:1284-93; West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. Lancet. 2016;388:2272-81.

[78] For further reading about this criticism, see Rapp, C. (2006). What Use is the Doctrine of the Mean? In B. Eis (Red.), *The Virtuous Life in Greek Ethics* (pp. 99-126). Cambridge: Cambridge University Press.

[79] Hursthouse, R. (1980). A False Doctrine of the Mean. *Proceedings of the Aristotelian Society, 81*, new series, 57-72. Retrieved May 28, 2021, from http://www.jstor.org/stable/4544965, p. 57-60.

[80] In the beginning of the twentieth century chemist Paul Ehrlich wanted to find what he called 'magic bullets' that would specifically target precise disease entities. This has to do with how medical reductionism intervenes with diseases. For further reading about reductionist medical interventions see Stegenga (2018): 73-76.

in which the patient feels heard and gets a custom treatment, or a five minute conversation after which he or she goes home with a standard drug prescription.

Similar arguments can be found in the literature, when it comes to the Virtue of Benevolence or the importance of communication. As Drane argues, a good doctor is one who perceives the fears of the patient and tries to alleviate them, whereas a poor doctor may not recognize these fears at all.[81] To gain this insight, the physician will have to be involved with the patient and see the patient as more than just a physical body. In addition, a good understanding of the patient makes medicine efficient because it will make diagnosis easier. On the importance of communication, Drane also writes: "doctors who do not talk to patients or do not talk enough, leave the patient with all sorts of mistaken notions; the diagnostic process is left incomplete and therapeutic effectiveness is curtailed."[82] Thus, the patient's perception and feelings are an important source of information when it comes to diagnosis. When diagnosis can be made efficient and easy, this will also contribute to the patient's healing process.

### 4.5 Respectfulness

In contemporary bioethics the notion of respect commonly refers to the respect for the patient's privacy or autonomy. In this context, The Virtue of Respectfulness is about respect for the patient's integrity. Integrity is a fundamental notion that is related to a person's honor, to self-esteem, self-worth, dignity and credibility, and to his morality. Those who see their integrity under attack experience this as a violation of wholeness and self-respect. Disease and illness are also considered as the absence of a person's wholeness. This has to do with the fact that the presence or experience of illness makes the patient vulnerable. Therefore, acquiring the Virtue of Respectfulness by the physician, is indispensable to the patient's healing process. The physician is morally obliged to preserve the patient's integrity, by respecting his or her personal values. Without respect, the patient will be reduced to an object or a number in a long line. A medical intervention from this perspective can be experienced as a violation. Therefore, it is the physician's task to reestablish the wholeness of the patient that contributes to well-being and health. Pellegrino & Thomasma write: " To ignore, override, repudiate, or ridicule the patient's values is to assault the patient's very humanity. This aggravated this dis-integration of the person that already exists as a result of illness. Nothing could be further from a morally defensible healing relationship."[83]

[81] Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, p. 159.
[82] Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, p. 49.
[83] Pellegrino & Thomasma, *The Virtues in Medical Practice*, p. 130.

## Conclusion

In this thesis, I have shown why virtue ethics in the Aristotelian tradition can have a place in the medical ethics by stating the following five arguments: First, medicine is a moral activity. Second, the biomedical model, and its attitude towards the patient, fall short. Third, virtue ethics also supports the doctor's well-being. Fourth, virtue ethics can help restore a climate of trust in contemporary health care institutions. Fifth, medical ethics cannot be based on rules and principles. Also, I have added new medical virtues to the existing lists of Drane and Pellegrino & Thomasma. By having done this, my specific goal was to describe how my list of virtues contributes to the patient's healing process. Practicing the virtues by the physician has proven to be beneficial not only for the patient, but also to the physician him- or herself. I have shown that by following the mean, physicians can also protect themselves against criticism and overburdening themselves.

In any case, it is necessary to refer to the fact that this thesis, because of its length, did not attempt to answer the question "can virtue be taught" and "how can virtue be taught". As we have seen, virtue ethics in the Aristotelian mode can be taught by practice and training, because a virtue is acquired by the ongoing practicing of the virtues. Therefore my results can function as a starting point for a follow-up research to examine how exactly virtue ethics can be taught during medical training, with the ultimate goal to arrive at a medicine grounded on virtue ethics.

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## VERKLARING KENNISNEMING REGELS M.B.T. PLAGIAAT

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Wetenschappelijke integriteit vormt de basis van het academisch bedrijf. De Universiteit Utrecht vat iedere vorm van wetenschappelijke misleiding daarom op als een zeer ernstig vergrijp. De Universiteit Utrecht verwacht dat elke student de normen en waarden inzake wetenschappelijke integriteit kent en in acht neemt.

De belangrijkste vormen van misleiding die deze integriteit aantasten zijn fraude en plagiaat. Plagiaat is het overnemen van andermans werk zonder behoorlijke verwijzing en is een vorm van fraude. Hieronder volgt nadere uitleg wat er onder fraude en plagiaat wordt verstaan en een aantal concrete voorbeelden daarvan. Let wel: dit is geen uitputtende lijst!

Bij constatering van fraude of plagiaat kan de examencommissie van de opleiding sancties opleggen. De sterkste sanctie die de examencommissie kan opleggen is het indienen van een verzoek aan het College van Bestuur om een student van de opleiding te laten verwijderen.

### Plagiaat

Plagiaat is het overnemen van stukken, gedachten, redeneringen van anderen en deze laten doorgaan voor eigen werk. Je moet altijd nauwkeurig aangeven aan wie ideeën en inzichten zijn ontleend, en voortdurend bedacht zijn op het verschil tussen citeren, parafraseren en plagiëren. Niet alleen bij het gebruik van gedrukte bronnen, maar zeker ook bij het gebruik van informatie die van het internet wordt gehaald, dien je zorgvuldig te werk te gaan bij het vermelden van de informatiebronnen.

De volgende zaken worden in elk geval als plagiaat aangemerkt:

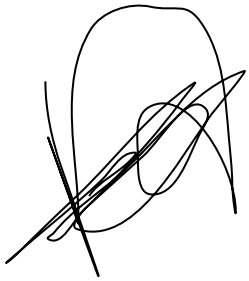
- het knippen en plakken van tekst van digitale bronnen zoals encyclopedieën of digitale tijdschriften zonder aanhalingstekens en verwijzing;
- het knippen en plakken van teksten van het internet zonder aanhalingstekens en verwijzing;
- het overnemen van gedrukt materiaal zoals boeken, tijdschriften of encyclopedieën zonder aanhalingstekens en verwijzing;
- het opnemen van een vertaling van bovengenoemde teksten zonder aanhalingstekens en verwijzing;

- het parafraseren van bovengenoemde teksten zonder (deugdelijke) verwijzing: parafrasen moeten als zodanig gemarkeerd zijn (door de tekst uitdrukkelijk te verbinden met de oorspronkelijke auteur in tekst of noot), zodat niet de indruk wordt gewekt dat het gaat om eigen gedachtengoed van de student;
- het overnemen van beeld-, geluids- of testmateriaal van anderen zonder verwijzing en zodoende laten doorgaan voor eigen werk;
- het zonder bronvermelding opnieuw inleveren van eerder door de student gemaakt eigen werk en dit laten doorgaan voor in het kader van de cursus vervaardigd oorspronkelijk werk, tenzij dit in de cursus of door de docent uitdrukkelijk is toegestaan;
- het overnemen van werk van andere studenten en dit laten doorgaan voor eigen werk. Indien dit gebeurt met toestemming van de andere student is de laatste medeplichtig aan plagiaat;
- ook wanneer in een gezamenlijk werkstuk door een van de auteurs plagiaat wordt gepleegd, zijn de andere auteurs medeplichtig aan plagiaat, indien zij hadden kunnen of moeten weten dat de ander plagiaat pleegde;
- het indienen van werkstukken die verworven zijn van een commerciële instelling (zoals een internetsite met uittreksels of papers) of die al dan niet tegen betaling door iemand anders zijn geschreven.

De plagiaatregels gelden ook voor concepten van papers of (hoofdstukken van) scripties die voor feedback aan een docent worden toegezonden, voorzover de mogelijkheid voor het insturen van concepten en het krijgen van feedback in de cursushandleiding of scriptieregeling is vermeld.

In de Onderwijs- en Examenregeling (artikel 5.15) is vastgelegd wat de formele gang van zaken is als er een vermoeden van fraude/plagiaat is, en welke sancties er opgelegd kunnen worden.

Onwetendheid is geen excuus. Je bent verantwoordelijk voor je eigen gedrag. De Universiteit Utrecht gaat ervan uit dat je weet wat fraude en plagiaat zijn. Van haar kant zorgt de Universiteit Utrecht ervoor dat je zo vroeg mogelijk in je opleiding de principes van wetenschapsbeoefening bijgebracht krijgt en op de hoogte wordt gebracht van wat de instelling als fraude en plagiaat beschouwt, zodat je weet aan welke normen je je moeten houden.

| |
|---|
| Hierbij verklaar ik bovenstaande tekst gelezen en begrepen te hebben. |
| Naam: Nikè van Wijck<br>Studentnummer: 5839912 |
| Datum en<br>handtekening:<br>  <br>25-06-2021 |

Dit formulier lever je bij je begeleider in als je start met je bacheloreindwerkstuk of je master scriptie.

Het niet indienen of ondertekenen van het formulier betekent overigens niet dat er geen sancties kunnen worden genomen als blijkt dat er sprake is van plagiaat in het werkstuk.