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# Virtue, Foible, and Practice — Medicine's Arduous Moral Triad

by Griffin Trotter

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*Moral distress is often discussed as a response to the moral dilemmas that professional and other caregivers encounter in their effort to balance competing moral principles, or to provide care in difficult cases, to difficult patients, in spite of difficult institutional requirements or policy. In this essay, a reforming ER clinician and teaching physician, offers a personal approach to moral distress. Assuming that a clinician's own foibles may sometimes contribute to another's distress, and that attempting to rationalize or subvert these foibles causes moral fatigue, he offers personal guidelines for healthcare providers — four strategies that less-than-perfect practitioners may use while striving to attain the ideal of the competent, compassionate, altruistic, calm, and wise clinician.*

This essay focuses on moral foible and how imperfect or not-quite-right-minded clinicians ought to address it. By “moral foible” I denote a minor weakness in moral character (a character foible), or an action that betrays such a weakness (an active foible). My line of reasoning is simple, and hinges on three successive insights.

First, given the all-too-apparent shortcomings of human nature, nurture, and resolve, most clinicians are moral foiblers. Second, clinicians' struggles to subvert, erase, rationalize, or forget their foibles often breed moral fatigue, which in turn begets cynicism and excessive detachment. Third, in order to succeed clinically — and ultimately to approach virtue — clinicians need to (a) acknowledge that they are not as virtuous as they'd like to be, (b) accept that the road to virtue is a long one, and (c) develop strategies to prevent character foibles from expressing themselves in active foibles.

In this essay the term “clinician” refers to physicians, nurse practitioners, physician assis-

tants, nurses, and other morally imperfect parties engaged in rendering clinical service. I am especially qualified for this study, given the magnitude and duration of my foibles as an emergency physician. I have, like many other clinicians, grappled with anger and resentment directed at patients who are aggressive or rude, or who seek care too early (when I think they should take care of themselves) or too late (when managing their problems becomes more difficult). I have growled at subordinates for minor mistakes and howled at colleagues when their opinions diverged from mine.

I have been callous where virtuous physicians offer tenderness and concern, and I have selfishly lamented my own discomfort — even while those in my care face unspeakable tragedy. In short, I have failed (and continue to fail) to express the moral virtues of the master physician. In what follows, my aim is to provide helpful guidance for clinicians who wish to do their best, given inevitable moral shortcomings that prevent them from being the William Osler or Florence Nightingale

that most of us hope to be.

While the abstract notion of the ideal physician remains relatively stable, specific job descriptions are increasingly ephemeral. On the administrative front, clinicians' financial incentives, referral structures, approval mechanisms, and other third party relations are in rapid flux. Clinically, patient demographics and standards of care also change rapidly, testing clinicians' adaptive powers. Yet contemporary clinicians are just as human as were their less harassed predecessors. They rage; they misconstrue; they tire; they misstep — and follow these failings with merciless self-flagellation. Such recriminations run deeper than mere consternation about particular slip-ups. When complicated by irreconcilable mandates, impossible expectations, and warring loyalties, consternation blossoms into a crisis of personal identity.

According to identity theorist Roy Baumeister (1986), there are two "defining criteria" of personal identity: continuity and differentiation. By "continuity," Baumeister refers to the process in

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which individuals achieve unity over time, often by embedding themselves in specific social roles and upholding prevalent behavioral norms. "Differentiation," on the other hand, is a process of distinguishing oneself from others. Recent work in bioethics has attempted to accommodate these processes by attending to the manner in which people construct "personal narratives," and "value systems." "Identity components" are whatever satisfies these defining criteria of identity.

The image of the ideal physician, fashioned largely in accordance with medical tradition, is a crucial identity component that provides continuity for most clinicians (while also providing a broad differentiating criterion). When clinicians

fail to measure up to this ideal, they experience frustration or crisis, depending on how dearly the image is held or how severe the shortcomings may be.

That such crises are common in contemporary medicine is abundantly clear. Revicki, Whitley, and Gallery (1993) found that emergency medicine residents — even with high levels of peer and work-group support and freedom — experience depression, stress, and dissatisfaction when they are unable to accommodate themselves to a workable and coherent professional ideal. In a study of practicing physicians in Israel (Carmel 1997), trait-anxiety correlated more strongly (inversely) with global self-esteem than did (positive) estimations of technical competence. Several other studies show that clinicians' perception of the moral ideal of a caring clinician is a more important factor in the selection of medicine as a profession, and in subsequent professional satisfaction, than other variables such as income, prestige, and academic interest (Hyppölä et al. 1998, McMurray et al. 1997, and Barondess and Glaser 1993).

The distress of clinician-foiblers, then, is related to their quest for virtue. Clinicians of all stripes are deeply committed to a moral ideal involving the embodiment of virtues such as beneficence, prudence, autonomy, and compassion (Eliason and Schubot 1995). Such commitments evolve into frustration when (1) inconsistencies emerge within the ideal or between competing interpretations of the ideal (e.g., when expressing one virtue entails compromising another) or (2) when, despite clear moral expectations, clinicians fall short. I have previously written at length (Trotter 1997) about the first source of frustration. In this essay, I address the second.

### **Before Virtue**

My professional crisis developed insidiously. It centered on no particular event and garnered little attention. Nevertheless, from my perspective it was an intense and transformative affair, facilitating whatever modest success I have subsequently enjoyed as an emergency physician.

In my second year of practice, Major Howell, a senior emergency nurse, beckoned me to his office. Anticipating a pleasant conversation with a favorite colleague, I smiled as I seated myself before his desk. The smile was not returned. Instead, Howell erupted into a passionate, vein-popping rebuff that wholly contradicted his usually easy-going demeanor. He railed about my overbearing treatment of emergency department staff and my increasingly captious and unpleasant demeanor. He was “sick and tired” of trying to come up with an acceptable schedule when nobody wanted to work with me. In explicit terms, Howell recited my faults and shouted that things were going to change — now!

Startled by this uncharacteristic outburst, I quickly perceived that Howell was accurate on all counts. His tirade confirmed what I had long suspected but never admitted, even to myself. Technical competence aside, I was failing miserably at the interpersonal dimension. I was not a good emergency physician. For months I had employed every available resource in ceaseless efforts to obscure this glaring reality. Meanwhile, foibles morphed into vices and dissatisfaction became cynicism.

“I am not a good emergency physician.” I repeated this refrain often through the sleepless days that followed. When finally brought to explicit consciousness, this negative insight initiated a salutary line of reasoning:

1. Because I lack enthusiasm, optimism, deep compassion, self-confidence and tact, I am not a good emergency physician.
2. It is not possible for me to develop these qualities quickly.
3. Yet I am obliged to go to work, see patients, and interact with colleagues.
4. Hence, until I develop the requisite clinical virtues, I must *pretend*. I must act as if I am a good physician.

In a manner reminiscent of Aristotelian trainees, I began to do the things that good physicians do.

Despite lingering dysphoria, I smiled whenever I walked into the emergency department. Despite feelings of irritation, I responded gently when technicians fumbled. Within a few weeks, Howell oozed delight over my increased popularity. The approval felt good, but my internal turmoil had eased only slightly. I felt like a fake and was constantly amazed when people didn't see beyond my feigned cheeriness. Meanwhile the energy required to maintain this grand facade was enormous. I expected something to explode.

It didn't. Instead I gradually developed a new homeostasis. My smile became habitual and, somewhat later, it began to feel genuine. Within six months I had accomplished a considerable transformation. I actually felt positive about my

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work and about my competence as an emergency physician. Feelings of charity, empathy, and compassion began to accompany actions designed to portray these emotions. Though I continued to foible (and at times to backslide), I developed a strong sense of vocation. I was on the path.

### **Practice Guidelines**

Years later, as an attending physician at a teaching hospital, the recollection of this experience became a special gift. Attuned to the disappointment and self-recrimination that afflicts medical trainees, I have often been able to offer helpful guidance. The following strategies summarize this guidance. They constitute a scheme of medical practice, where “practice” is understood in the basic semantic sense. The master clinician, that vague constellation of virtues that each of us must hone into a living, personal ideal, is recognized as a difficult and faraway goal. Though foibles are inevitable and intractable, we can practice the behaviors that characterize our ideal. Gradually foibles will dwindle as practicing clinicians approach the asymptote of clinical virtue.

## 1. *Accept the Plateau*

The best articulation of this strategy comes from former *Look* magazine editor and Aikido artist George Leonard (1991). According to Leonard, our journeys toward personal or professional ideals conform to a number of characteristic patterns. The first, and probably the least prominent in the medical profession, is that of the dabbler. Dabblers move quickly from one ideal to another, changing course whenever rapid progress slows to frustrating stasis.

The second pattern, the obsessive, is common in medicine. Obsessives, like dabblers, will embark on a new occupation or pastime with great zeal and revel in a sense of rapid improvement. However, as with any worthwhile endeavor, their progress eventually becomes slow and difficult. An initial upward slope of thrilling accomplishments gives way to a plateau or even a brief period of regression. Rather than quit, as per the dabbler, obsessives redouble their efforts.

With regard to the ideal, obsessives are uncompromising: it must be realized as quickly as possible. Their intensity, however, is not enough to produce steady improvement at the rate they expect. Inevitably they will experience periods of stall — despite their Herculean effort. Somehow, obsessives are never willing to accept that difficult ideals are difficult or that the plateau is an inevitable aspect of personal development. They become frustrated and perhaps even defensive. Eventually they withdraw.

In medicine there are many withdrawal routes. One may change careers or specialties. More often, one employs defense mechanisms — concluding that the ideal is unrealistic or unimportant, rationalizing unprofessional behavior, blaming the system, or following other pursuits while viewing professional life as merely a necessary evil. The result, for those who remain in the profession, is cynicism and detachment.

A third pattern of behavior at the plateau is also common in medicine. Leonard calls it the hacker. In this version, the inevitable plateau is accepted

as a final resting-place and the ideal is forgotten altogether.

A good example is the golfer who is content to shoot in the 90s rather than accept the effort (and the initial dip in performance) of changing his swing. Mastery is no longer a consideration. Clinician-hackers are quite content knowing that they are mediocre doctors or nurses. Never quick to read the medical journals or learn about the latest clinical strategies, they fulfill minimum requirements. Of course, hackers are not apt to read this essay (nor will they engage in any other supererogatory efforts at self-improvement). Hence, my concern is primarily to help the obsessive.

To move beyond the plateau, one must first accept that there are and must be plateaus. Leonard says we should love the plateau. Perhaps “love” is too strong a word — spurts of improvement are intrinsically more lovable — but he is right: it is possible to experience fulfillment during periods in which self-improvement seems to stall. Rather than respond with a frenzy of worry or self-recrimination, we do better to maintain a steady course, to calmly persist in training.

A lag is rarely the time to multiply one’s efforts; occasionally the plateau may even signal a need for temporary rest. In any case, master physicians, like their kin in athletics and other realms, exhibit a nearly universal capacity to enjoy life on the plateau. They revel in practice (or “training” as athletes often call it) and derive keen enjoyment from the simple rhythms and rituals of their daily regimens. Mastery, they know, is not an end result. It is a life-long challenge, engaging them at every juncture.

Emergency physicians, for instance, should tune themselves to the pleasures of suturing a laceration, performing a rapid-sequence intubation, or tickling out a complicated medical history. In one study (Keller and Koenig 1989) veteran emergency physicians cited “proficient use of skills” 4.5 times more often than “variety and excitement” as a source of satisfaction in medical practice, yet “variety and excitement” was fifteen times more important than the “proficient use of

skills" for early emergency medicine trainees. At some point, the successful emergency physician learns that thrilling new accomplishments, novel challenges, and climactic moments are insufficient sustenance for life on the plateau.

## 2. "Just do it."

Many of the current generation will trace this strategy to Bo Jackson and his Nike commercials, but actually Aristotle recommended it years earlier. In *Nichomachean Ethics*, Aristotle observes that "states of character are formed from similar activities" (1103a14b25). Virtue for Aristotle is a state of character in which an individual acts in a morally correct manner and also (1) knows that this is the right way to behave under given circumstances, (2) chooses the right action for its own sake, and (3) the act flows from a permanent disposition.

To become virtuous, according to Aristotle, we must learn the correct behavior (condition 1) and perform it accordingly, even if other conditions (2 and 3) do not yet apply. Eventually, through repetition, the right behavior will bring pleasure (or at least feel so natural that not doing it would be acutely painful). At this point, conditions 2 and 3 will follow – the moral agent will do the right thing habitually, for its own sake.

To train for virtue, Aristotle recommends two crucial strategies. First, we must discern an appropriate moral ideal. Perhaps we will acquire a worthy mentor (as Aristotle explicitly recommends) or possibly we will fashion an image of the virtuous individual by observing and studying the lives of virtuous others. Second, we should act in accordance with our ideal, even when such activity seems difficult, uncomfortable, or unnatural. In other words: just do it. Eventually the good acts will seem natural — they will issue from a stable, virtuous character.

One should not be fooled by the simplicity of this advice. Coupled with an attitude that accepts the inevitability of plateaus, this strategy is liberating and potent. My crisis in emergency medicine is a case in point. Though I often felt grouchy and captious, I resolved to

act pleasantly and generously. Eventually these actions produced pleasant and generous feelings.

## 3. Cultivate Empathic Equipoise

In his seminal lecture "*Aequanimitas*," William Osler (1932) describes the medic's essential attitude — which I call "empathic equipoise." This is the virtue of proper engagement. Osler describes the virtuous physician as one who is calmly removed from the high emotions and human tragedies that dominate hospital wards and emergency departments. Osler, who admired the

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stoics, may have removed himself a little too far. Others are inclined to emulate those who remain more engaged — individuals like Mother Teresa or Francis Peabody, for instance. Nevertheless, Osler's advice is particularly helpful for medical trainees.

Empathic equipoise is the appropriate middle ground between detachment and excessive engagement. Though many insightful commentators have recommended a more pronounced emphasis on empathy and care, the emphasis on caring is not always helpful. These critics are interested in reaching individuals and institutions that focus too closely on impersonal principles, who view medicine primarily as a technological enterprise, who recommend a stoic posture, or who drift away in the throes of a failed ideal. Still, many conscientious clinicians and trainees

are highly sensitive and caring. Paradoxically, caring too much, sharing our patients' suffering too intensely, or clobbering ourselves when we fail to feel compassionate are forms of excessive engagement that can produce burnout and withdrawal, exactly what the "ethics of care" hopes to avoid.

There is a sliding scale for empathic equipoise. If we are highly sensitive and empathic, we should endeavor to be more detached. If, on the other hand, we experience distance, or a cold sensation that we've seen it all, we must strive to be open-minded and compassionate. This advice, once again, etches an Aristotelian trajectory. Aristotle recommends that in choosing the actions that will produce virtue, we should aim to the side of the more difficult excess. Medical trainees (usually but certainly not always) tend to be overly emotional and excessively self-conscious. Later in our careers, the opposite is frequently the case.

I recall being approached by an internal medicine intern who was rotating through the emergency department. Near tears, she told me she was unable to obtain a medical history from her patient. He had spit at her, chided her about the size of her breasts and other physical features, and then utterly refused to answer personal questions. He ended by threatening her life. Despite the importance of locating illness within the context of a patient's personal narrative, it is unreasonable to expect physicians — especially younger, more inexperienced ones — to calmly elicit a detailed personal history in such aggressive or seriously unfriendly patients (Trotter 1998).

Though the intern wanted me to take over the care of this patient, I didn't. "Detach yourself," I told her, "and obtain as much information as possible without dwelling on or reinforcing his ugly behavior. And concentrate on the general goals of medicine. If he is in pain, give appropriate doses of analgesia. Bracket the illness and look for a disease. If you find one, offer treatment. This may be Cartesian medicine, but it is the best you can do to help your patient. If you lose your cool now, it may not be possible to make a closer connection later when things have calmed down."

Such advice doesn't pertain only to interns. Even after fifteen years in emergency medicine, I often experience spasms of anger or outrage, and must default to this Cartesian perspective.

#### **4. Rehearse Mentally**

One advantage of empathic equipoise is the ability to replay one's foibles mentally without experiencing emotional breakdown. Calmly recalling unsuccessful clinical actions makes it possible to engage in constructive self-criticism and fashion strategies for doing a task right the next time. On the other hand, if we are overwrought or steeped in self-recrimination, the recollection of failure becomes too painful to be productive. In the latter case, rationalization, self-loathing, or depression are the more likely results.

Empathic equipoise is a standpoint from which we can review our clinical foibles in the posture of an athlete reviewing game films. Even more than athletes, clinicians must rely on mental rehearsals to prepare for high-stakes future engagements. We practice resuscitation techniques, for instance, both mentally and in dry runs to prepare ourselves for nerve-wracking clinical exigencies. The case is no different with morally challenging circumstances involving hostile patients or dysfunctional colleagues.

#### **Conclusion**

These four strategies are helpful, even essential; but they are not enough to launch or to sustain a journey to clinical mastery. A crucial spark is missing — a spirit of loyalty that each clinician must kindle of his or her own will (though certainly not merely subjectively or alone).

Loyalty is a willing, practical, and thoroughgoing devotion to a social ideal (Trotter 1997, Trotter 1999). Many claim that the Hippocratic ideal is obsolete, unreliable, or tired (Beauchamp and Childress 2001), and, while exaggerated, their point has merit. How many medical students or clinicians lie awake at night musing on this tradition or reverently contemplating its oath? It seems that medicine is involved in the spiritual crisis of

trying to find a suitable moral ideal.

Perhaps, as Kuczewski (1997) and others suggest, bioethics should be at the forefront of efforts to refashion medical values into a new idea that quickens the pulse of future clinicians while enticing the approval and support of society at large. According to Kuczewski, we are involved in a process of mutual self-discovery, aimed at broad social consensus. I think, however, that Emanuel's (1991) suggestion is more likely, namely, clinicians will rekindle their moral imagination by tapping the wellspring of local allegiance — to families, churches, professional associations, community projects, and manifold other sources of evolving moral values.

In any case, our image of the ideal clinician is in flux. Before we can train diligently in pursuit of clinical mastery, we must sharpen the features of this vague image — at least to the point where we have something to grasp. I doubt that it is possible or even desirable to carve out a single visage, fit for all. Moral pluralism runs too deep for that. Nevertheless, it should be possible to bring our diverging moral communities into respectful dialogue, cooperating when possible, and adorning our respective moral ideals in the fine raiment of toleration, commitment, and compromise — as befits the rank of master clinician.

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