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Theory and Principles

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Virtues and Goals in Pediatrics

G. Kevin Donovan and Edmund D. Pellegrino

VIRTUE ETHICS REVISITED

Most physicians, whether they treat children or adults, would not see themselves as having much in common with philosophers. Philosophy is often thought to deal with the abstract, ethereal, or abstruse, whereas medicine is scientific, evidence-based, and goal-directed. Nevertheless, when physicians are questioned, they readily accept that some of the attributes of philosophers are similar to their own. A physician is a seeker of knowledge, one who pursues the application of the right treatment to the right diagnosis for the good of the patient. Doctors tend to be most fulfilled when they have a deep appreciation of both their patients and their profession, the personal interaction as well as the intellectual stimulation of the medical profession. Ultimately, this makes a physician a seeker of truth and wisdom, which is not a bad definition for a philosopher. Although some might shy away from this connection, thinking that to discuss their philosophy of medicine or their philosophy of life would seem somewhat pretentious, most physicians would readily admit to wanting to be a "good" doctor. But what does it mean to be a good doctor? What does it mean to do good in the medical sense? When prodded, we could produce a list of traits that would characterize a good physician. Such lists have been produced before; such traits have been described. The term most often used in these descriptions is "virtue."

Virtue has often been defined as the good character traits of such persons, that is, their disposition to habitually do the things that are right and good. Ultimately, the character of one performing an action is central to the good choice of action. It is the recognition of this truth that has formed the basis of virtue ethics since the time of the ancient Greeks. Aristotle said that "moral virtues are states of character, a disposition to excellence that makes one a good man and causes him to perform his function well."[1] As one of us has pointed out, virtue is the most ancient, durable,

and ubiquitous concept in the history of ethical theory. This is so because one cannot completely separate the character of a moral agent from his or her acts, the nature of those acts, the circumstances under which they are performed, or their consequences. Virtue theories focus on the agent – on his or her intentions, dispositions, and motives – and on the kind of person the moral agent becomes, wishes to become, or ought to become as a result of his or her habitual disposition to act in certain ways.[2]

Although the concept of virtue was both durable and ubiquitous in theories of ethics from the Greeks to more modern times, it always had its deficiencies. Conceptual difficulties inherent in the concept of virtue itself led to challenges to a theory of virtue ethics and its gradual falling into disfavor, as described by Alasdair MacIntyre.[3] Virtue ethics was supplanted by other approaches following the Renaissance and the Age of Reason. Part of this was a result of the disarray of normative ethics in general, and part was due to problems with virtue-based ethics in particular. Virtue ethics does not emphasize principles, rules, duties, or concrete prescriptions. It does not, therefore, tell us how to resolve specific moral dilemmas. It says only that a virtuous person will be predisposed to act in accord with the virtue appropriate to the situation. For many, following this circular reasoning feels like trying to nail Jell-O to the wall. If a good thing is that which a virtuous person would do, then a virtuous person is one who would do the good. We must define either what is good or what a virtuous person is in order to avoid this circularity, and it is just these definitions that have challenged philosophers throughout the ages. Moreover, virtue theory cannot stand alone, any more than can other normative theories, without some concept of what kind of person the moral agent is, or is striving to become. For instance, a deontology-based ethic would focus on the act itself, whether it is right and good. But the individual is judged only by whether his or her moral conduct is in accord with a universal norm – for example, utility, justice, or beneficence. It sheds little light on the intention of the moral agent and ignores important aspects of the interaction, such as virtue or caring. A more consequentialist approach relies on an outcome that maximizes good for the most people, balancing goals and resources and considering the needs of everyone affected. In this way, we expect to produce the greatest good for the greatest number. Such a focus on good outcomes is very appealing to those trained in medicine and public health. Difficulties arise in the attempt to find agreement on which values should be maximized, and we begin to see that the values of the moral agent are not inconsequential. If the goal is to maximize happiness, then both the definition of happiness and the interplay between the (virtuous) person and the production of happiness, for oneself and for others, becomes problematic if this approach is used alone.

In the development of virtue ethics, it was necessary to examine the connection between virtue and happiness. Are people virtuous in order

to be happy, or are they happy because they act virtuously – is virtue truly its own reward? Is virtue to be pursued for its own sake or for "excellence" or "nobility"? In Western culture, a synthesis of classic and medieval philosophy derived a sustained answer to this. Thomas Aquinas developed a virtue-based ethics that began with the same elements as Aristotle's. He saw truth as the end point of the natural intellectual virtues, and the good of humans as the end, or "telos," of the natural moral virtues.

To this, he added the virtues of faith, hope, and charity, as defined by Christian theology. There existed an objective moral order in which human nature could be understood by human reason and that thereby defined the telos of human activity. For the Greek philosophers, the telos was natural happiness, but it was understood by Aquinas to be supernatural happiness, achieved by union with God. Virtues, then, were traits that habitually disposed humans to act in accord with the objectives or ends of human nature. The virtues were seen as having normative force, not because they were admirable in themselves, but because they would predispose one to achieving those desired ends, the good of human beings. Beginning at the time of Enlightenment, these sources of morality were challenged and the ancient Greek philosophies were devalued. Virtues were replaced by competing concepts – for example, rights (Locke), duty (Kant), moral sentiment (Hume), and consequences or utility (Bentham and Mill). Even when these other concepts were considered, the question of the character of the agent could not be entirely ignored, and so the importance of the virtuous person was never entirely discounted. Nevertheless, in the present day it is unlikely that the concept of virtue ethics could be widely accepted in society, given the lack of agreement on a definition of human good or the proper telos of human activity.

VIRTUE ETHICS AND MEDICINE

The concept of virtue as a normative theory for medical ethics paralleled the history of the concept of virtue in general ethics, yet it persisted from the time of the Hippocratic oath well into the 20th century. In the past generation, cultural and societal changes have led to an emphasis on consumerism, diminished trust in authority figures such as physicians, and an emphasis on autonomy-based relationships on the part of patients. These were closely linked to a weakening of the moral consensus that had provided the basis of professional ethics, and the growth of alternative approaches to ethics, such as principle-based ethics, and more particular approaches based on feminist ethics, narrative, and caring. Consequently, the dominance of virtue in medical ethics has diminished.

The absence of a generally accepted norm of virtue ethics in general ethics need not prevent a return to virtue in professional ethics.[2] There are good reasons to suppose this is possible. First, there is growing

dissatisfaction with the incompleteness of principle-based ethics, one that is guided solely by reference to the principles of autonomy, beneficence, and justice. This approach fails to account for the complexity of moral problems in medicine or to consider the need for compassion and humility in human interactions.[4] Such theories require a more solid and expansive base in a philosophical system in order to achieve normative force. Moreover, there is a common understanding that the individual character of the physician, or bioethicist, cannot be left out of the moral equation. The kind of person doing the analysis or performing the action will have an effect on the action that is chosen no matter which theoretical approach is being employed. Finally, in the domain of professional ethics, unlike general ethics, there still exists a real possibility of agreement on generally acceptable ends – the goals of medicine.

GOALS

In an attempt to define the values at the core of medicine and to reach some consensus on the goals of medicine, a report was produced by an international project of the Hastings Center.[5] Leaders representing 14 countries, primarily but not exclusively Western democracies, published their perspectives on the proper priorities. They acknowledged the differences between general societal goals and a specific professional ethic, stating, "Medicine must have its own vital life and its own clear direction. It should listen to what societies want. … yet in the end, it must chart its own course in partnership with society." They listed four goals for medicine:

- The prevention of disease and injury and the promotion and maintenance of health
- The relief of pain and suffering caused by maladies
- The care and cure of those with a malady and the care of those who cannot be cured
- The avoidance of premature death and the pursuit of a peaceful death

They considered these goals to be universally valid because of our common human nature, the inescapable fact of illness, pain, and suffering, and the growing universalization of scientific knowledge and medical skills. In doing so, they also rejected too broad a concept of health, such as defined by the World Health Organization (1947). Rather than attempt to ensure "complete physical, mental, and social well being," their definition focused on medicine as a response to a malady of the individual. Thus, they returned the focus to the doctor–patient interaction, while at the same time acknowledging that medicine as a profession is distinct and "must have its own internal compass and abiding values … resting upon its traditional and largely universal goals."

In fact, the work of this international group can be summarized and condensed into a single concept: the goals of medicine must serve the good as found in and defined by the doctor–patient relationship. In the doctor–patient relationship, most would agree that the proper end point should be the good of the patient. The good of the patient has been characterized by an action that is both right and good: *right* according to medical standards of effectiveness, achievability, and likelihood of providing a beneficial outcome, and *good* according to the desirability of this benefit, as judged by patients' values.[6]

VIRTUE ETHICS IN PEDIATRICS

If such a general goal of medical activity can be agreed upon, then those attributes that lend themselves to it may be seen in light of this goal. Virtues specific to medical activity can be described in this context and serve as instrumental goods that lead to the ultimate goal of the medical interaction, the good of the patient. Therefore, a professional virtue is defined in terms of the end point of the clinical encounter. "Healing is the activity specific to nursing and medicine. Those dispositions that impact the capacity to heal well are the virtues of medicine, nursing, dentistry, and the like. They are the virtues internal – in MacIntyre's sense – to the practice.[3] Possession of these internal virtues defines the good nurse or physician."[2] We have attempted a listing of such virtues and considered their application to the practice of pediatrics. Not everyone will agree with what is included, what is omitted, and why. Such lists are notoriously difficult to compile and cannot be thought of as all-inclusive. Therefore, one should feel free to add one's own choices to our list of virtues and propose even better examples of their application.

THE CARDINAL VIRTUES

The virtues wisdom, fortitude, temperance, and justice are considered cardinal (from Latin for "hinge") by Plato and Aristotle, in that all the others hinge on these four. They are not the only or even the highest virtues, but are essential for the existence and functioning of other virtues.[7]

Prudence, or Wisdom: Solomon asked for an understanding heart, and prudential wisdom is essential for the discerning physician. To come to the proper conclusions while weighing alternatives in the midst of clinical uncertainty requires good judgment; similarly, wisdom guides us in weighing apparent conflicts among values and virtues and selecting the best course for the good of the patient. This can be even more problematic in the care of children, where parental preferences may or may not reflect the good of the child and the patient's values may not have had the opportunity to mature. It is considered proper to look to parents for decisions

about what is good for a child. Although we act as if a suitable proxy can exercise the autonomy of the nonautonomous child, this is not altogether an unreasonable fiction. The definition of "autonomy" is not only "self-will," but also "respect for others." In this sense we defer to parents or other appropriate proxies to make decisions for those without this capacity, not applying the patient's (nonexisting) values, but acting in their best interests (see Chapter 3). In such cases, balancing multiple interests will require a great deal of prudential wisdom.

Courage: Here we define courage not as physical bravery, but as fortitude or strength of character. In the clinical setting, our judgment about diagnosis or treatment may not be in perfect accord with those around us. Abraham Lincoln said, "Be sure you're right, then go ahead." The first half of his maxim requires prudential wisdom, the latter, courage. It is no less a necessity in the face of moral dilemmas, especially when one's convictions place one against the tide in order to protect the vulnerable infant or child. A need for moral courage may arise in many disputes involving vulnerable children in such areas as truth telling (Chapter 6), brain death (Chapter 18), and feeding and caring for the severely brain damaged. On such occasions, we may at times find ourselves at odds with colleagues and families. Other virtues, such as humility, should temper our action, but at times we must stand fast, particularly because children are unable to speak adequately for themselves.

Moderation, or Temperance: This is a daily requirement for those who deal with potentially rowdy children, noncompliant parents, or the general frustrations of the health care system. It may seem at times that all physicians, and particularly those who deal with children, must behave as "super-adults." Such self-restraint is often necessary to maintain a workable doctor–patient relationship. It is needed and justified even more when the patient is a vulnerable child, and it is the parents who are demanding, noncompliant, or unreliable. We must restrain ourselves, having chosen to care for children even when their caretakers choose to act like children.

Moreover, Aristotle's "moderation in all things" should also guide us in seeking a necessary balance between the demands of our professional and personal lives.

Justice: To deal with each patient equally is to render according to his or her needs, treating like cases alike but different cases differently. In the relationship with a specific patient, the needs of distributive justice in society become secondary to the needs of that individual and the requirement for a healing action directed at his or her condition.

Nevertheless, the requirements of justice will also propel us to make improvements in the health care delivery system, for the good of all, as well as our particular patients. This is governed in part by the next virtue.

Fidelity: In professing to be able and willing to help in a medical relationship, the physician makes a commitment to ensuring that his or her

interests coincide with or defer to the needs of the patient. This commitment creates the trust without which a healing relationship cannot function. This commitment manifests itself in ways large and small: in being responsive to the child's needs and those of the parents, even when this is inconvenient; in truth telling; and in the maintenance of professional skills and competence.

Benevolence: Making the good of the patient one's intention is the sine qua non of the doctor–patient encounter. It is the virtue that underlies the principles of beneficence and nonmaleficence. It starts with the Hippocratic promise to do no harm, but extends into every treatment, every action, every test ordered or unnecessary intervention avoided. Because the younger and more vulnerable child relies on us to define and pursue what is right and good, this bedrock of benevolence will guide our actions on behalf of all, from the smallest (Chapters 8 and 10) to the more mature, from tested treatments (Chapter 15) to those being developed (Chapters 5, 9, and 13).

Altruism, or Effacement of Self-Interest: This is a virtue that draws many to the practice of medicine in the first place, motivates them to get up in the cold and dark of night, and to provide care to the needy. It is often leeched out of the individual in the process of medical training.

Compassion: Closely coupled to the previous two virtues, and flowing from them, compassion enables us to keep in mind the humanity of the sufferer, to avoid both callousness and a coldly intellectual approach to the treatment of his or her disease. We especially must maintain compassion for children, who are often not responsible for their medical predicaments, and try to avoid facile judgments about those who may be.

Humility and Intellectual Honesty: Last but not least, humility is the lynchpin of constant learning. Physicians are given pride of place in a medical hierarchy and often come to believe it is their duty and privilege to make the right decision for patients. It may become difficult to admit that they sometimes just do not know what is medically correct. In such cases, the doctor may err by keeping too narrow a focus, blaming treatment failures on the family's noncompliance, or stubbornly repeating the same diagnostic or therapeutic mistake. We may fail to listen to the patient or may fail to seek wiser counsel. Such pride comes at a cost, but the patient pays for it.

To all of these, Aristotle would have added gentleness, friendliness, and wittiness.[1] The first two are treasured virtues in a pediatrician, but we are pleased with the last one as well. We firmly believe that gentle humor is a good antidote for a child's anxiety and even serves to alleviate the monotony of medical routine. It should never be hurtful or sarcastic, and self-deprecating humor is the best of all.

The restoration and maintenance of virtue as a guiding force in professional ethics is not only possible, but vital. It depends on those who want to become virtuous, who are willing to ask themselves at each critical juncture, "Is this action compatible with the kind of physician I want to be?"

To many, this will be the determinative question; unfortunately, for some it will remain irrelevant. The practice of medicine will depend heavily on the former, those reflective and introspective souls who are determined to seek the best in themselves and for the profession. It was with such people in mind that this ancient Greek saying was printed in the journal *Pediatrics* more than a decade ago:

> A doctor has opportunities for studying human nature which are given to no one else, wherefore a philosopher ought to begin his life as a doctor, and a doctor should end his life by becoming a philosopher.

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Contributions of Ethical Theory to Pediatric Ethics

Pediatricians and Parents as Co-fiduciaries of Pediatric Patients

Laurence B. McCullough

INTRODUCTION

It might at first appear that pediatric ethics is sui generis, but it is a mistake to think so. Consider the well-known clinical ethical concept of pediatric assent. This ethical concept was pioneered in the 1980s by Sanford Leikin[1,2] and endorsed in 1995 by the American Academy of Pediatrics.[3] Pediatric assent recognizes that minor children cannot be accorded the legal right of informed consent but that older minor children, especially adolescents with chronic diseases, are capable of adult-like decision making about the clinical management of their diagnoses. The ethical content of the concept of pediatric assent is that, to the extent that their capacity for decision making and its exercise is adult-like, children should, with very few exceptions, be treated as having authority over themselves. Assent might appear to be unique to pediatrics, but it is not.[3] It also bears on the authority that should be given to decision making and its exercise by older patients with the diminished decision-making capacity that results from progressive dementing disorders.[4] In other words, the ethical concept of geriatric assent should guide decision making with geriatric patients who lack intact decision-making capacity.

Rather than being understood to be sui generis, pediatric assent should be understood to be professional medical ethics applied to the specialty of pediatrics and its subspecialties. The core ethical concept of professional medical ethics is the ethical concept of the physician as fiduciary of the patient.[5,6] In this chapter, I will show that pediatricians have the fiduciary ethical obligation to protect and promote the health-related interests of children. I will also show that parents are in an ethically parallel relationship with their child when their child is a patient. Parents also have the fiduciary obligation to protect and promote the health-related interests of their child who is a patient. Parents also have a fiduciary obligation to protect and promote the other, non-health-related interests of their child who