

Physicians in political roles: Would Hippocrates and Aristotle approve?

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1. Introduction and Research Question

Physicians, past and present, take on political roles, either within their communities, or at the provincial or federal level, perhaps leaving their medical practices to do so. Physicians have held recent positions in the Canadian government both at the federal and provincial level.

What could be reasons for physicians taking on political or other community leadership roles?

Where would such individuals acquire their training? Did they have an interest in the political

field? And, since taking on this role would likely mean departure from medical practice, is this

move to politics at an overall benefit to society? Furthermore, how does this political role affect

their overall wellness? How does a leadership role, with or without ongoing clinical practice affect

physician morale and contribution to society's overall wellness?

I obtained my medical degree in 1994, and since that time, I have had the privilege of assuming roles in different health care environments. I have a particular interest in exploring some of the above questions as I have witnessed various challenges to the medical profession, both to physicians and to patients. I will attempt to address these questions, through discussion of the doctor-patient relationship, as well as the relationship of the doctor to society as a whole. To begin, I will provide relevant background information concerning medical ethics and bioethics, the laws in Canada that apply to health care, and the professional associations that assume the role of physician regulation. Next, the physician-patient relationship will be discussed, including the evolution of the relationship with the resultant increased importance of patient autonomy. The doctor-patient relationship has undergone several changes and despite these changes, it continues to be strongly influenced by the Hippocratic Oath. Furthermore, the virtues of Principlism and many of those codified in the Hippocratic Oath can be found in Aristotle's Virtue

ethics theory. The ethics of the Hippocratic Oath and Virtue ethics framework as per Aristotle will then be used to describe the important applicable virtues to today's physician-patient relationship. Depending on the specific context of the practice, other ethical theories may play a part in the doctor-patient relationship. In my literature review, I will refer to authors from different backgrounds and with sometimes differing views, who have written about the Hippocratic Oath, and about virtue ethics. When exploring the doctor-patient relationship, challenges to the relationship emerge, such as the dilemma faced in certain dual type doctor-patient relationships, and these will be explored further. Due to many of these challenges, there is potential for erosion of the physician-patient relationship, and consequent negative outcomes to patients, to the physician and to society. The personality factors more specific to the physician will be discussed in order to understand how the physician can be at risk for certain health concerns and to provide an understanding as to how this risk can be mitigated. Through the frameworks of the Hippocratic and Virtue ethics, I will then argue that there is an overall benefit to physician wellness and to society for doctors to take on political roles. The involvement of physicians in political decisions will be discussed in keeping with Virtue ethics and as an extension to the traditional one-on-one doctor-patient relationship as referenced in the Hippocratic Oath. The relationship between the physician and society will be explored with support from Aristotle's view of the political life seen as the ultimate goal of happiness. In this scope, Benjamin Constant's view on political liberty will be used to further support Aristotle's argument. Constant argues for the liberty of the ancient cities of Sparta and Rome, where citizens believed in political liberty and the individual was considered sovereign in public affairs but a slave in private relations. I will discuss the more recent development of the social contract, a contract described between the physician

and society, and the implications of this contract to patient care and to the physician who wishes to practice virtue-based ethics. I will further refer to the ethics of the Hippocratic Oath to argue that the Hippocratic Oath is strategically placed to reinforce the need for physicians' political roles. In this regard, I will encourage the related ethical and leadership training, which may need to start in medical school, and consequently, the recital of the oath at graduation. I will discuss Aristotle's practical wisdom and how this is comparable to a physician reaching a professional identity by way of teaching, experience and challenges. The Hippocratic Oath will be presented as a means to reinforce virtue-based ethics while maintaining professionalism. Discussion will be focused on ongoing physician wellness, greater good for society, and overall happiness for physician, patients and society.

The research question to be answered is the following: How do the Hippocratic Oath and Virtue Ethics portray and encourage higher moral reward and satisfaction for physicians, and how can the Hippocratic Oath recital of physician goals best serve doctors and patients in today's health care systems and ultimately, communities?

2. Background information relevant to the Physician-Patient relationship

a. Medical ethics

Bioethics is the modern term that applies to the not only ethical issues relevant to clinical care, but the moral, legal, political and social issues raised by medicine, biomedical research, and life sciences technology (Singer 1). The three broad and interconnected spheres of bioethics are: academic bioethics, public policy and law bioethics, and clinical ethics. In this paper, my discussion

will apply to the third sphere, this being how the incorporation of bioethics into clinical practice can help to improve patient care. One of the most well known frameworks of Bioethics has been developed by Tom L. Beauchamp, (The Theory, Method and Practice of Principlism; Section IV Philosophy and Psychiatric Ethics) in the four-principled approach. Principlism is described as a framework of four principles, and a method for putting these principles to work in practical ethics. The four principles, which are described as abstract norms of obligation, and starting points for moral reflection, are: respect for autonomy, nonmaleficence, beneficence and justice. Autonomy is based on liberty, meaning the absence from controlling influences, and agency, meaning self-initiated intentional action. In applying the common morality theory to these principles, principlism occupies a central place within moral life. Principlists also attest that the four principles selected are part of a larger set of principles in the common morality, which include in addition, virtues (universally admired traits), moral ideals (such as mentoring colleagues, or charitable goals) and universal human rights. Beauchamp notes that professional moralities contain codes, declarations and standards of practice that vary from other particular moralities, but continue to share the common moralities. Through the process of specification and reflective equilibrium, the principles become concrete and practical in addressing a particular ethical situation. Some of the criticisms of Principlism include that this method is seen as too blunt of an instrument to apply in all circumstances, and too insensitive to the complexities and tensions inherent in morality. The moral principles of this theory will be seen again in the discussion of Virtue ethics and the ethics of the Hippocratic Oath that will follow.

b. The laws in Canada applying to our health care and to the regulation of physician practice

The Constitution Act of 1867 divides the legislative powers relevant to the regulation of the delivery of health products and services between the federal and provincial levels of government

The Canada Health Act of 1984 consists of:

1. Universality: all eligible residents are entitled to public health insurance coverage on uniform terms and conditions
2. Portability: coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country;
3. Public Administration: the health insurance plan of a province or territory must be administered on a non-profit basis by a public authority;
4. Accessibility: reasonable access by insured persons to medically necessary hospital and physician services must not be impeded by financial or other barriers,
5. Comprehensiveness: all medically necessary services provided by hospitals and doctors must be insured (“Canadian Health Care System”).

As per the website of the CPSO (College of Physicians and Surgeons of Ontario), the role of the College and its authority and powers are set out in the *Regulated Health Professions Act (RHPA)*, the *Health Professions Procedural Code*, which is Schedule 2 to the *RHPA*, and the *Medicine Act*. In addition, there are regulations made under both the *RHPA* and the *Medicine Act* (“Legislation & By-Laws;Policies & Publications”).

c. Physician professionalism organizations

According to the web page of the University of Ottawa medical school (“The Emergence of Professionalism”), "professionalism" encompasses a reaffirmation of the values and behaviours of physicians. The ideals of professionalism include altruism, trust, integrity, honesty, morality, and confidentiality. The attributes of a healer are not typically encompassed in the professionalism ideals, as professionalism dictates the obligations of medical practice. As per William M. Sullivan, ‘It is the function of medicine as a profession to safeguard and promote this trust in the society at large’ (Sullivan 675). There are regulating bodies to assure that medical professionalism is maintained. In Ontario, the mandate of the licencing body of physicians, the College of the Physicians and Surgeons of Ontario, is the following:

- *Build and maintain an effective system of self-governance.*
- *The profession, through and with the College, has a duty to serve and protect the public interest by regulating the practice of the profession and governing in accordance with the Regulated Health Professions Act (“Quality Professionals, Healthy System, Public Trust, About the College. College of Physicians and Surgeons of Ontario”).*

3. The Physician-Patient relationship

I will begin by discussing the Physician-Patient relationship, first as portrayed and interpreted in the passages of the Hippocratic Oath, and then through the lens of Aristotle’s Virtue ethics.

a. Through the lens of the Hippocratic Oath

The Hippocratic Oath dates back to the times of ancient Greece. It continues to be recited by medical school graduates in modern medical schools. It is a tradition that is shared, accepted and seen as an achievement at the time of graduation. *First, do no harm*, which came to be attributed to Hippocratic medicine, is seen as one of the building blocks of medical teaching and medical decision-making. This is understood and respected by most patients and citizens of our community as it refers to the pursuit of therapy involving a weighing of the benefits and harms. The Hippocratic Oath is not simply a strong bonding exercise on graduation day; it is described as the 'most admired work in Western European medical ethics' according to *The Hippocratic Oath and the Ethics of Medicine* (Miles v). The Oath has been studied and interpreted by many scholars including Edmund Pellegrino, Robert M. Veatch, Steven Miles, and Dr. Richard Cruess and Dr. Sylvia Cruess, whose works will be explored.

Some of the earliest origins of the physician-patient relationship are described in the Hippocratic Oath, which is thought to date to approximately 400 BC. It is not known who actually composed it, and may not have represented the views of the physicians of that time. It appears that it was rediscovered by medieval church scholars and began to be used in medical school graduation ceremonies in the United States and Europe starting in the eighteenth century. Steven Miles describes the Oath as having a similar structure to the case presentation models used in modern medicine. This is likely one of the features of the Oath that makes it attractive as a ritualistic medical school rehearsal. Casuistry, described as 'problem solving by comparing cases' has a long history in disciplines including philosophy, ethics and medicine, and is a method of medical teaching. By comparing similarities and differences between cases, diagnoses and

management solutions could be clarified. Casuistry is described as a difficult art, and despite the extent to which the Oath may or may not address the ethics of today's modern medicine, its evaluation of the medical ethics of its time is ground breaking and a teaching tool in many respects (Miles 9).

The Oath professes as to the importance of sharing of medical information for the purposes of enhancement of medical knowledge, which is again echoed in the present day medical schools and teaching hospitals.

Four of the six core values currently recognized in biomedical ethics, these being beneficence, non-maleficence, justice and confidentiality, are in keeping with the ideas codified in the Hippocratic Oath (Mountokalakis 229). Nonmaleficence, which is related to the well known statement 'do no harm', is associated with the Hippocratic Oath, however, it is not clear how this term arose and is described as having an overrated utility, likely due to some overlap with beneficence. Beneficence and Justice are quoted in the following passages of the oath:

I will use regimens for the benefit of the ill in accordance with my ability and my judgment, but from (what is) to their harm or injustice I will keep (them). This quote is thought to refer to beneficence and justice in the public sphere, such as public health ethics.

Into as many houses as I may enter, I will go for the benefit of the ill, while being far from all involuntary and destructive injustice, refers to ethics in the private sphere, and more specifically to beneficence, the doctor-patient relationship, respect of autonomy and informed consent.

The doctor-patient relationship is described in the Oath in the passage that discusses the ethics of the physician in the patient's private world in which the clinical encounter occurred.

About whatever I may see or hear in treatment, or even without treatment, in the life of human

beings-things that should not ever be blurted out outside-I will remain silent, holding such things to be unutterable (sacred, not to be divulged), clearly refers to the one-on-one doctor patient relationship and the importance of confidentiality within this relationship. John Arras, in his article entitled “A Method in Search of a Purpose: The Internal Morality of Medicine”, refers to the importance of the clinical principle of confidentiality which is the premise of patients’ disclosure of information (Arras 646). Without maintaining confidentiality, patients will not be inclined to divulge important information to their physicians, information that is required for their care. *In a pure and holy way I will guard my life and my techne* makes reference to integrity of the physician, and dual loyalty problems in managed care, including in military or in occupational medicine. Various challenges to medical confidentiality will be discussed later in this paper.

The doctor-patient relationship has changed from the traditional paternalistic model since the 1970’s. In the past, the physician’s opinion dominated, however, as individuals become more knowledgeable about medical conditions, many wish to contribute to decisions about their health. In Canada, this became even more important with the adoption of the Canada Health act, and with the emergence of universal health care. Over these last decades, priority has being given to patient autonomy, with resultant greater patient choice and control over medical decisions. Rather than informed consent being about patient agreement to the physician’s decision, informed consent has evolved to become patient oriented. The physician has a duty to provide appropriate medical facts and to assist the patient in determining future interventions. In evaluating the four types of Physician-Patient relationship models, these being the Paternalistic, Informative, Interpretive and Deliberative models, the latter is determined to be most ideal according to Ezekiel J. Emanuel and Linda L. Emanuel’s article titled, “Four Models of the

Physician-Patient Relationship". However, different circumstances merit the use of different models. For example, the Paternalistic model is most appropriate in emergency, life threatening situations, while the Informative model, where the physician's role is limited to providing information, may be appropriate in cases where patients have clear values which are conflicting with medical recommendations. Using the Deliberative model, through moral discussion with the patient, the physician informs the patient and tries to persuade the patient as to the best, the most admirable treatment. In the Deliberative model, the physician is not coercing the patient, but acting as a teacher, and discussing health related values affecting the patient's decision. The assumption is that the physician's recommendations should not depend on a judgment of the patient's values, and therefore, the values of the physician should not be brought into the discussion. Overall, this model seems to reaffirm the autonomy of the patient in providing them with freedom and control. The difference with the Paternalistic model is that in the Deliberative model, the physician does not proceed with treatment until the patient is in agreement. The patients are autonomously assessing their own values and preferences then freely deciding as to their treatment, as per the following the steps: 1. A critical assessment of values and preferences 2. Determination as to whether these values are desirable 3. Reflection and affirmation of these values, and 4. Free initiation of the actions in keeping with the values (Emanuel and Emanuel 2225).

In reflecting back to the Hippocratic Oath on the subject on the physician-patient relationship, the opening passage provides background information on the foundation of medicine. *I swear by Apollo the Healer, by Asclepius, by Hygeia, by Panacea, and by all the gods and goddesses, making them my witnesses that I will carry out, according to my ability and*

judgment, this oath and this indenture. Reference to these ancient gods puts emphasis on the family nature of the practitioner and interpretation includes a reconceptualization of medical ethics in a multidisciplinary health care system. This passage is seen as supporting collaborative practice models with more sharing of authority, accountability, and reimbursement in improving health delivery (Miles 178–179). The medical ethics of the Oath are centered on beneficence and justice, as is seen by promoting the benefit of the ill and keeping them from injustice. Beneficence is further portrayed by engaging the physician in promoting health in society, such as in public health and human rights. Although autonomy is not addressed as a distinct entity, it has been argued that beneficence should encompass autonomy, perhaps through ongoing casuistry and application of core medical ethical principles (Miles 181). *Now if I carry out this oath, and break it not, may I gain for ever reputation among all men for my life and for my art; but if I transgress it and forswear myself, may the opposite befall me,* refers to the responsibility and accountability of the physician to his patient and to society, irrespective of the model of the physician-patient relationship within a particular historical context. The passages, *I will not give a drug that is deadly to anyone,* referring to abortion and *I will not give a woman a destructive pessary* referring to refusal of medical euthanasia are not as categorical and continue to generate heated debates in today's health care.

There have been both supporters and critics over the years with respect to the recital of the Hippocratic Oath during graduation from medical school, and this will be discussed further. Richard and Sylvia Cruess have written that it would be important to maintain the oath as part of a graduation 'ritual' for medical doctors, but that an amendment would be needed, in keeping with

changes in today's health care system, to encompass physician duties that indirectly impact on the doctor-patient relationship, such as elements of cost efficiency in today's health care (2014 97).

Edmund Pellegrino, when arguing about the medical profession as a moral community, refers to the Hippocratic Oath. He distinguishes between physicians' obligations to individual patients and the obligations of the profession as a moral community, dedicated to a common set of moral precepts. He refers to the Hippocratic Oath as portraying a model of a moral community. He admits that some of the inferences referring to sons and brothers would be considered paternalistic and sexist in today's modern societies, but concludes that there is a clear sharing of moral obligations to those within the profession, which has persisted across the ages and in various cultures. He talks about physicians being held to a higher standard of ethical conduct than that of other professions and that it may be no longer possible to be an ethical physician without the collective moral force of the whole profession (Pellegrino 1990 222). Pellegrino wrote that the ethic of the Hippocratic Oath was no longer the moral binding force of the past. He spoke of a new lacking morality of the profession where collaboration was no longer about what is best for patients, including resisting of policies that undermine patient care and ethics, but more about remuneration. His final recommendation at that time was for health professionals to dedicate themselves primarily to the care of the sick, and not to self-interest and for professional organizations to fulfill their moral responsibilities to the public; then there would be an overall benefit to health care (Pellegrino 1990 231). In his 2012 paper, Pellegrino reaffirmed the need to reset the moral compass of the medical profession. By reciting an oath at graduation, the members promise publicly to be competent and act in the interest of the sick, and therefore, to become part of the physician moral community. He reaffirmed the importance of medical ethics

as being the predecessor of bioethics. These ethics of medicine are in keeping with the ethics of the Hippocratic Oath, and of Virtue ethics. His view was that both medical ethics and bioethics need to coexist to better serve the good of patients (Pellegrino 2012 24).

On the topic of the Hippocratic Oath, Robert Veatch states that it has emerged from a Greek mystery religion, and advises that the Hippocratic ethic is dead and should be allowed to rest in peace. His view is that both the Hippocratic Oath and the Declaration of Geneva must be firmly rejected in favor of codes which lay people help to write. He affirms that professionally generated codes are unacceptable, as the codification of the proper practice must involve public agreement (Veatch 1999 211). In a later article titled, "Hippocratic, religious, and secular ethics: The points of conflict" Veatch also challenges the four principles of the theory of Principlism, and describes his seven principle theory (Veatch 2012 41) in which he teases out the concept of autonomy into fidelity, veracity and avoidance of killing.

Richard and Sylvia Cruess provide a less radical view. They have written about the obligations of physicians to patients, but also to the profession and furthermore, to society. Since the Oath appears to concentrate on medicine's obligation to society, it is suggested that the Oath not be discarded, but be updated to better reflect the obligations of both the individual doctors and the medical profession to society (Cruess and Cruess 2014 95).

In summary, the Hippocratic ethics, seen through the Hippocratic Oath, continue to be relevant in certain parts of medicine. This is seen predominantly in the physician-patient relationship, which has evolved from that described in the Hippocratic Oath, yet, according to authors such as Pellegrino and Cruess, continues to be applicable to the medical field. The recital of the Hippocratic Oath has been a topic of dispute, and Cruess has offered a compromise, with

the idea of a relevant adjustment to the oath, so that the recital, thought to be an important bonding experience, can continue to take place.

b. Through the lens of Aristotle and Virtue Ethics

The virtues applicable to the medical field include beneficence and nonmaleficence, two of the components of Principlism, as well as the virtues of temperance, generosity, even temper, friendliness, truthfulness, and justice, which are clearly Aristotelian virtues. In the next paragraph, I will attempt to illustrate, through the use of quotes from Aristotle's *Nicomachean Ethics*, several virtues applicable to the medical field. At the basis of the Virtue ethics theory, is the 'good' and 'happiness', and in the following passage the 'good' is described as the aim for every action:

According to Aristotle's *Nicomachean Ethics* (NE)

'Every skill and every inquiry, and similarly every action and rational choice, is thought to aim at some good; and so the good has been aptly described as that at which everything aims' NE1094a.

'Clearly, it is human virtue we must consider, since we were looking for human good and human happiness. By human virtue, we mean that of the soul, not that of the body; and happiness we speak of as an activity of the soul' NE1102a.

In applying Virtue theory ethics to the medical field and to the physician-patient relationship, the objective of care is clearly providing the 'good' to the patient. Through deliberate, virtuous action, the welfare of the patient will be assured. The virtuous person deliberates and makes the rational choice. In *Nicomachean Ethics*, it is stated:

‘An indication of this is the fact that we call people practically wise in some particular respect whenever they calculate well to promote some good end that lies outside the ambit of a skill; so where living well as a whole is concerned, the person capable of deliberation (long and careful consideration or discussion) will also be practically wise’ NE 1140a.

Practical wisdom, which is seen as an important step towards happiness, is further explored when I discuss physician involvement in politics.

Justice is identified as one of the virtues, which also applies to medical ethics as discussed by Beauchamp and Principlism ethics. Aristotle speaks of equity in the context of justice, and that an equitable person chooses rationally and does equitable things. He also speaks of justice in a context which may apply to situations of conflict of interest:

‘Justice is the only virtue considered to be the good of another, because it is exercised in relation to others: it does what is beneficial for another, whether he is in office over one or is a fellow citizen’ NE1130a.

‘Justice is a kind of mean-not in the same way as the other virtues, but because it is concerned with a mean, while injustice is concerned with extremes’ NE1134a.

The principle or virtue of justice is often at the core of ethical dilemmas in medicine, as is injustice. Aristotle speaks of distributive justice,

‘For if the persons are not equal, they will not receive equal shares; in fact quarrels and complaints arise either when equals receive unequal shares in an allocation, or unequals receive equal shares’ NE1131a.

‘This is clear also from the principle of distribution according to merit. For everyone agrees

that justice in distribution must be in accordance with some kind of merit, but not everyone means the same by merit; democrats think that it is being a free citizen, oligarchs that it is wealth or noble birth, and aristocrats that it is virtue' NE1131a.

In other words, merit and value are not always equal to monetary compensation, and not everyone has the same perception of being valued and rewarded. For physicians, according to their personalities, there is a need to be valued and appreciated. In today's society, value and valuelessness are often conveyed by increases or decreases in monetary compensation.

The doctrine of the mean is applicable to concepts in medicine, such as autonomy and consent, since often, the best outcome is obtained by accepting a partial autonomy (Rai and Rai 23).

'every expert in a science avoids excess and deficiency, and aims for the mean and chooses it- the mean, that is, not in the thing itself but relative to us'

'...excess and deficiency ruin what is good in them, while the mean preserves it'

'Virtue, then, is a state involving rational choice, consisting in a mean relative to us and determined by reason- the reason, that is, by reference to which the practically wise person would determine it. It is a mean between two vices, one of excess, the other of deficiency' NE1106b.

Aristotle also speaks about practical wisdom, and how it requires virtue of character therefore it develops and operates in those who have had the correct upbringing and habits. In the medical field, this would translate to education, training and experience as we will explore later.

Friendship is both a virtue and involves the exercise of virtues and can be applied to the

relationship between physician and patient.

'So virtues arise in us neither by nature nor contrary to nature, but nature gives us the capacity to acquire them, and completion comes through habituation' NE1103a. Being friendly towards, or loving, falls into three categories: the good, the pleasant and the useful, and these three categories of friendship could apply to the doctor-patient relationship. The ideal relationship is based on virtue, as affirmed by Pellegrino, who discusses Aristotle's moral virtues, and applies these to the ethics of the profession in the article entitled "Character, Virtue, and Self-Interest in the Ethics of the Medical Profession: Part I: The Erosion of Virtue and the Rise of Self-Interest". He argues against the erosion of virtue and the rise of self-interest in the ethics of the medical profession (Pellegrino and Gray 1994 30), and in part II of the series, he discusses restoration of virtue, both in general and in professional ethics (Pellegrino and Gray 1994 44).

Veatch (1999 214) speaks of a resurgence of Virtue theory, and how Care theory is put forward as the prevailing or dominant virtue in health interactions. However, for many virtues, he acknowledges that it is often difficult to agree upon which virtues to follow. He argues that health care in a different country may not necessarily be based on the same set of virtues, which makes the Virtue theory impractical to apply to ethics of health care (Veatch 2012 37).

In Pellegrino's 2012 paper, he argues that any ethical theory can be shaped and converted from benevolence to malevolence, however, virtue is the element of medical ethics that is unavoidable and uncompromisable. This is in keeping with Aristotle's view on cleverness:

If the aim is noble, then the cleverness is praiseworthy; if it is bad, then it is villainy. This is why both practically wise and villainous people are called clever' NE1144a.

'A physician who possesses the art of medicine has the expressive excellence to know the

too much and the too little, guided by a sense for the good....and so medicine, like all human practices, contributes to eudemonia' (Landes 276).

Therefore, the virtues important to the physician-patient relationship, including justice, friendliness, truthfulness, and temperance are clearly described in Aristotle's *Nicomachean Ethics*. In addition, there are inferences to distributive justice and the doctrine of the mean, which are applicable to today's health care. Both Pellegrino and Veatch have acknowledged the resurgence of virtue ethics in the medical field although they have differing views with respect to degrees of applicability. Now that I have discussed the physician-patient relationship and have explored the view of several authors, let us move to the complexities of the relationship that can ensue.

4. The Complexity of the Physician-Patient relationship

The physician-patient relationship is dynamic and changing, and influenced by factors intrinsic to physicians and patients, as well as extrinsic factors outside of the relationship. Most of these factors are interrelated, therefore, one can affect the other and add to the overall complexity of the physician-patient relationship. I will describe the physician, patient, and system factors in more detail, which will be important to review prior to commencing discussion of the possible erosion of the relationship.

a. Physician factors

According to the article by Glen O. Gabbard, "The Role of Compulsiveness in the Normal Physician", hallmark psychological characteristics of physicians include: compulsiveness, doubt, guilt feelings, perfectionism, and excessive sense of responsibility for things beyond one's control,

as well as, difficulty setting limits. When it is not extreme and pathological, compulsiveness makes for diagnostic rigor and a thorough physician. The need to be needed is another facet of the physician personality; there is a strong need to be loved, valued and needed by patients (Gabbard 2926). Research has shown that doctors have significantly higher rates of mental health problems than the general population—including alcohol and drug addictions, tendency to self-medicate leading to prescription drug abuse and depression (Brooks, Chalder, and Gerada 157; Berge, Seppala, and Schipper 625).

Physician health concerns may or may not be related to the profession, however, addressing the health concerns and obtaining treatment are problematic for the physician who has been trained in self-denial (Miller and McGowen 971). As discussed further below, work related concerns include the health care system factors and these may negatively affect physician morale and health. In addition, physicians have increased professional obligations, which require that they maintain competency not just in evidence-based medicine but also in legal, ethical and financial health care societal matters. Moreover, the expectations of society, which are inherent to the profession, relate to the physician as a 24-hour compassionate healer. They often work long hours outside of regular hours and carry worries from their work home with them. They are a healer to friends, family and acquaintances who informally seek advice and reassurance. It is difficult to 'turn off work' and disengage from work, and often this is a role that is accepted and that becomes part of the inherent makeup of the individual and a way of life. It is also a role that may be embraced and sought, as it provides community recognition and appeals to their need to be valued. This is likely the explanation for leisure time being problematic for physicians, who tend to react to stress by working harder in their professional activities instead of taking holidays.

Furthermore, there are challenges to the physician's existence. Due to the financial and nonfinancial benefits, the physician may find himself or herself having to justify their existence and income. This public scrutiny is made worse by the threats and aftereffects of malpractice that may be due to maleficent physicians. The legal pressures may increase the anxiety about missing important new developments. There is an overwhelming amount of negative publicity relating to physicians as overpaid and immoral, and increased pressure on regulating colleges and ministries of health. The community's perception, if negative, becomes a deterrent to obtaining this moral recognition sought by most doctors, therefore other factors which increase the scrutiny of the public may be challenges to the physician's morale and health.

b. Patient factors

In the face of a greater aging population, and the elderly requiring more health care than younger people, there will be increasingly important issues of autonomy that arises, as well as ethical concerns about voluntary and informed consent. Some of the following statistics exemplify the challenges to health care:

Statistics Canada reports that over 15% of our population at the last census was over 65 years of age; it was 7.6% in 1960. Based on population projections the share of Canadians 65 and older will continue to rise and by 2024 they will account for 20.1% of the population. By 2036 seniors are expected to make up 25% of the population. Approximately 75-80% of Canadian seniors report one or more chronic condition. The number of Canadians living with dementia is expected to rise 66% over the next 15 years ("The State of Seniors Health Care in Canada").

Other factors complicating the relationship may include patient expectations, which may not be attainable due to scarcity of resources. Alternatively, patients should expect to be treated ethically and respectfully, and lack of such treatment may lead to patient suffering and a complaint to the physicians' colleges.

c. System factors:

These factors include medical and technological advances. More types of procedures, and more types of treatments are available and each modality carries a rate of success along with a risk of morbidity or death. These must be carefully explored, understood, and explained to patients, who together with their physicians, decide whether the risk of any given intervention is warranted. Such a scenario would take place, for example, in the setting of cancer diagnosis, where therapeutic options may involve surgery, chemotherapy, and radiation therapy, in various order and strengths. There are risks as well to diagnostic procedures, for example, as in performing an angiogram for diagnosis of coronary artery stenosis and cardiac ischemia, which carries a risk of mortality that varies depending on the patient's medical status and experience of the physician. In the domain of medical research, the goal is for advancement in research and treatments, but at times, this entails unknown risks to the subjects who may have no other potentially curative treatment options.

Other societal factors include economic constraints with resultant lacking resources and long wait times for diagnostic testing or treatment. Economic constraints also affect the salaries of physicians, leading to pay cuts, emergence of competing lower paid providers, and disagreement with political leaders and the public.

Different types and environments of medical practice exist, where the question of a conflict of interest may arise. This includes the physician being in a dual relationship. This dilemma to the physician-patient relationship is well described in Pellegrino's article titled "Societal Duty and Moral Complicity: The Physician's Dilemma of Divided Loyalty" (1993 371), and in Chapter 7 of the Cambridge textbook of Bioethics (Singer 2012 43-48). There are threats to the individual physician-patient relationship for physicians who work in a dual role, for example in a Military, Public Service setting, or other Occupational health setting where there is a potential conflict of interest between the interests of the individual patient, and that of the employing body. There is a threat of compromise of the medical consent and confidentiality of the patient for the sake of the good of the larger organization. In circumstances of a dual role of physicians, from the medical ethics point of view, and in keeping with Hippocratic principles, it is important that release of medical confidential information take place only if the risk to the public outweighs the right of the patient's right to maintain the privacy of their medical information. There are strong moral arguments in favor of maintaining confidentiality, which include the notion that patients will not withhold information when they do not fear that their private information may be shared with others. Of most importance is the clinician's duty to respect patient autonomy in medical decision-making, because competent patients have a right to control the use of information pertaining to themselves. A clinician who shares that information with others, without the patient's consent, does not respect the patient's autonomy and, therefore, is considered to have behaved in a morally questionable way, even if no harm has resulted. Another moral consideration for the importance of confidentiality arises from the nature of the doctor-patient relationship. There is an implied promise that confidences will be respected in this relationship, and it is the clinician's duty

to keep this promise, otherwise risking a betrayal of trust. There are strong moral counterarguments of maintaining confidentiality stemming from Utilitarian ethics. Most often, agreement will ensue in maintaining confidentiality, however, a serious harm to the patient or others is seen as a reason to justify a breach of confidentiality. Settings for which this counterargument may apply include the research setting, or the public health setting where the benefit of the common good may outweigh the harm to the individual's loss of control over their personal data. According to John Stuart Mill, 'personal freedom may legitimately be contained when the exercise of such freedom places others at risk of harm' (Singer 2012 44) which suggests that the individual's personal freedom and autonomy may need to be compromised if maintaining this autonomy places others at risk. At that time, 'the duty to preserve confidentiality, no longer takes precedence and disclosure without the patient's authorization may be permissible as required' (Singer 2012 44).

According to modern medical ethics, there is a distinction between confidentiality and privacy. Confidentiality refers to the duty to safeguard information and privacy refers to the individual's right in this regard, but both terms are often used interchangeably. Although the Hippocratic Oath and the International Code of Ethics of the World Medical Association profess strict adherence to confidentiality, more recent professional codes of ethics, such as that of the Canadian Medical Association ("CMA Code of Ethics") account for a breach of confidentiality if required by law, or when there is a significant risk of serious harm to others.

Disclose your patients' personal health information to third parties only with their consent, or as provided for by law, such as when the maintenance of confidentiality would result in a significant risk of substantial harm to others or, in the case of incompetent patients, to the

patients themselves. In such cases take all reasonable steps to inform the patients that the usual requirements for confidentiality will be breached. (CMA 2004, last reviewed 2015)

The American Medical Association has similar information in their code of ethics with respect to confidentiality: (“The Code of Medical Ethics of the American Medical Association”).

For any other disclosures, physicians should obtain the consent of the patient (or authorized surrogate) before disclosing personal health information (AMA Principles of Medical Ethics: III, IV, VII, VIII, 2016).

And according to the British Medical Association’s Confidentiality and Health Records Tool Kit, *‘doctors appointed and paid for by a third party still have a duty of care to the patient whom they advise, examine or treat, and must abide by professional guidelines on ethics and law’* (“BMA - 15. Dual responsibilities”).

The role of pharmacological companies and real or perceived conflict of interest of physicians can complicate the physician-patient relationship. Studies have demonstrated that physicians can be influenced in their choice of prescriptions, by the subliminal or explicit benefits provided to them by pharmaceutical companies (Macneill, Kerridge, Newby, Stokes, Doran, Henry 335; Schultz 169). Due to the increased publicity supporting influence of companies on physician’s prescription practices, patients may question the treatment provided by their physicians. As a result, they may not comply with recommended treatment, especially if this involves a newer, more expensive medication.

There is an increased societal need to take on financial duties for which the physician may not have the training and tools to undertake. Previously the doctor did not have the role of taking

costing, finances, and budget into account when providing recommendations that were traditionally evidence based scientific or medical advice. Addressing the monetary cost of a given intervention to society may be seen as posing a conflict of interest situation for the individual doctor-patient relationship. However, avoiding addressing cost may mean potentially not benefitting the society as a whole. For example, recently, NACI (the National Advisory Committee on Immunization) has provided advice on cost-benefit analysis of immunization: *Economic Evaluation of Vaccination Against Pneumococcal Disease in Elderly Adults in Canada*, which entails an evaluation of the cost effectiveness of different vaccination strategies (“Summary of Discussion February 10-11, 2016 Meeting, Ottawa, Ontario”). This cost-benefit analysis may be provided by pharmacological companies, which may or may not be taken into account for recommendations due to a potential real or perceived conflict of interest situation. It has been observed that there are gaps in Canadian vaccine evaluation capacity, and delay in the approval of vaccines which may be related to delay in cost benefit analysis. Consequently, quicker approval may lead to protection of more individuals in society at risk from the disease in question (Scheifele et al. 767 ; Chit et al. 1257).

As we have explored the difficulties that may arise in the physician-patient relationship, it is now possible to discuss the erosion of the relationship that may ensue, with resultant poor outcomes for both physician and patient. At this time, I will outline the outcomes affecting the physician, in order to then discuss mitigating factors by involvement in the political realm.

5. The erosion of the Physician-Patient relationship : resulting negative outcomes for the

Physician:

Negative health outcomes that are increasing and common in physicians include professional burnout, substance use disorders, and suicide (Miller and McGowen 966). Burnout, which affects 30-45% of practicing physicians (Albuquerque and Deshauer E502) is a syndrome characterized by emotional exhaustion (loss of enthusiasm for work), depersonalization (feelings of cynicism), and a low sense of personal accomplishment. Burnout may erode professionalism, influence quality of care, increase the risks for medical errors and promote early retirement. Burnout may also lead to broken relationships, alcohol dependence and suicidal thoughts (Shanafelt et al. 1377). According to Shanafelt, the origins of the problem are likely rooted in the environment and care delivery system rather than in the person characteristics of individuals. Therefore, this problem needs to be addressed by policy makers and health care organizations. It is likely that contributors to physician professional burnout include excessive workload, loss of autonomy, inefficiency due to excessive administrative burdens, a decline in the sense of meaning derived from work, and difficulty balancing professional and personal lives. The six areas in the work environment that contribute to burnout are work overload, lack of control, insufficient reward, breakdown of commitment, absence of fairness, and conflicting values (Gabel 421). Most interventions have centered on individual measures, such as stress reduction techniques, or promotion of self-awareness. Although these techniques are beneficial, they are not appealing to all physicians due to the investment of personal time, which is already lacking. However, it is likely that there is a need for organizational interventions, including system factors to be put in place to address risk factors such as workload. The fact that physicians are at higher risk of burnout than

other workers may point to risk factors intrinsic to physicians that increase their risk, such as personality factors, as well as the extrinsic factors that include increased responsibilities and expectations, and lack of community support.

Michael P. Leiter, Erika Frank and Timothy J. Matheson (2003) have explored the interaction between workload and burnout, and physician engagement and have concluded that both values congruence and workload contribute to burnout amongst physicians. Incongruence of personal values and moral strain contributing to burnout, occur when health care professionals' values are not aligned with the values of the health care organizations or groups with which they're working (Gabel 2001). The values of the organizations may not be about beneficence, justice, or autonomy, but about limiting resources and maximizing revenues. They found that work overload contributed to predicting exhaustion and cynicism and that crises involving professional values contributed to predicting exhaustion, cynicism, and low professional efficacy. The congruence of personal and system values predicted not only physicians' energy and involvement, but also the physicians' professional efficacy. There is a negative relationship between the burnout indicators, these being exhaustion, depersonalization and diminished efficacy, and the outcomes of job satisfaction, patient satisfaction, and self-assessed quality of care. These factors are considered to be on the continuum from job burnout to work engagement. Therefore, it may be the case that a challenge to physician values not only increases the risk of burnout, but also decreases job satisfaction and professional efficacy. Health care organizations need to put policies in place in view of these risks, and the solution is not to try to preselect physicians who appear less prone to burnout, as they may be less committed to their work (Collier 1980). Joy Albuquerque and Dorian Deshauer looked at some of the institutional responses to physician burnout, and

these include attempts to improve civility within the workplace, leadership training, raising awareness of the condition and implementing feedback mechanisms to address work overload and systemic inefficiencies (E502).

As a result, physicians who have entered the medical field, often with the best of intentions to serve the patients, may become disillusioned. 'The idealism that drew the clinician to the healthcare profession, that call to care, now seems but a distant memory and a cruel joke' (Ford 295). They may decide to leave the practice altogether. They may try to seek reward elsewhere, perhaps in a field which is less physically or psychologically demanding. Alternatively, they may look for monetary gain at the expense of moral reward, taking on business ventures that may compromise their physician ideals. Whatever the route, the final destination is one of physician exodus or illness, which, in all likelihood, will lead to compromise in overall patient care.

In the 1990's physician health programs were set up in most Canadian provinces to help physicians access care, recover from illness and safely return to work. Not only are doctors at risk for illness and addiction, but they need to be able to take responsibility and to seek treatment without fear of retribution (Albuquerque and Deshauer E502). And, in addition to helping individual doctors, there are increasing numbers of programs that address risk-management for the profession. This involves raising awareness of health risks and providing physicians with doctor referral services, reinforcing group communication, and creating hospital programs. Health, by becoming a professional value, will hopefully be seen as a priority for physicians, organizations and patients. This exemplifies the present shift of making physician health a public concern, and a political issue. Efforts have been put in place to address physician wellness. One such program exists at the University of Ottawa Faculty of Medicine, and according to their website, 'At the

University of Ottawa, Faculty of Medicine, the well being of all members of our Faculty continues to be of the highest priority' ("Faculty of Medicine Faculty Wellness Program").

6. Physician Political Involvement

Political activities, broadly speaking, are those that are intended to alter understanding, beliefs, practices, and policies in external institutions, communities, and government (Gruen 97). In the discussion that follows, I will try to demonstrate that the involvement of physicians in political roles is in keeping with Aristotle's view of involvement in the polis and thereby, that such leadership in the community can have a positive contribution to physician wellness. Discussion will be in keeping with virtue ethics, and in an extension of the traditional one-on-one doctor-patient relationship referenced in the Hippocratic Oath.

a. Through the lens of Aristotle and Virtue Ethics

As per Aristotle 'while the good of an individual is a desirable thing, what is good for a people or for cities is a nobler and more godlike thing' NE1094b. Aristotle's beliefs in assuming political roles are seen in the quotes that will follow, taken from his works, *Nicomachean Ethics* and *Politics*. He speaks of the life of politics, happiness and honour being interrelated. He compares a life without political involvement to a sad life of isolation, without a home, and without family.

'There are three especially prominent types of life: that just mentioned (pleasure), the life of politics, and thirdly the life of contemplation' NE1095b. 'Sophisticated people, men of action, see happiness as honour, since honour is pretty much the end of the political life' NE1095b. 'The

human being is by nature a social being...'NE1097b. According to Aristotle's The Politics, 'It follows that the state belongs to the class of objects which exist by nature, and that man is by nature a political animal. Anyone who by his nature and not simply by ill-luck has no state is either too bad or too good, either subhuman or superhuman-he is like the war-mad man condemned in Homer's words as 'having no family, no law, no home'; for he who is such by nature is mad on war: he is a non-cooperator like an isolated piece in a game of draughts' Politics1253a1.

The physicians' incentive to take on a political leadership role can be compared to Aristotle's view of friendship (NE1156a), where the three types of friendship are virtuous friendships, friendships of utility, and friendships of pleasure. Aristotle believes that the most desired friendship is the virtuous type. Therefore, for the physician in the political realm, the possible incentives are the following:

1. Seeking of moral reward by contribution to community improvement, with an overall benefit to society, with no intention of harm to society; this is comparable to the virtuous type of Aristotle friendship
2. Seeking of power and improved social status for individual reward, with little or no consideration of community benefit; this is comparable to the utility type of Aristotle friendship
3. A conscious choice of leaving clinical practice, which may be due to realization of poor fit, fear of litigation, burnout, dissatisfaction with patient care, or other reason for choosing to change employment. This is comparable to the 'pleasure' (or removal from displeasure) type of Aristotle friendship.

According to Aristotle, only the virtuous can have genuine friendships. Consequently, in this

analogy, the natural and sought after *telos*¹ for each human being is the involvement in the polis.

This can be further supported by the following passage where virtue, an activity of the soul is portrayed as the route for the objective, the political *telos*.

‘Human happiness is a life of fully actualized virtue, of activity of the soul in accord with reason, this is the political *telos*. Some external goods are needed for such a life and luck to some extent, but guaranteeing the virtue of the state is based on ‘knowledge and choice’ Politics1332a.

Again in the context of friendship, conflict of interest and priority for the truth, which are two areas of importance as seen in the discussion on the physician-patient relationship, are addressed in the following passage.

‘It will presumably be thought better, indeed one’s duty, to do away with even what is close to one’s heart in order to preserve the truth, especially when one is a philosopher. For one might love both, but it is nevertheless a sacred duty to prefer the truth to one’s friends’ NE1096a.

Aristotle introduces the three types of especially prominent types of life, these being the lives of gratification, politics and study (NE1095b). He dismisses the life of gratification, stating that this is for the ‘coarsest people, for the masses’. With respect to politics, he reflects on the importance of honour alongside virtue. Since honour involves feedback from society, and the need to be valued, it is a component of the personality of most physicians. For many professionals, including physicians, honour is an important component of their work.

¹ *telos* is the purpose of life according to Aristotle, this is the path to *eudaimonia*, human flourishing and happiness

'Sophisticated people, men of action, see happiness as honour, since honour is pretty much the end of the political life. Honour, however, seems too shallow to be an object of our inquiry, since honour appears to depend more on those who honour than on the person honoured, whereas we surmise the good to be something of ones' own that cannot easily be taken away. Again, they seem to pursue honour in order to convince themselves of their goodness; at least, they seek to be honoured by people with practical wisdom, among those who are familiar with them, and for their virtue. So it is clear that, to these people at least, virtue is superior.

One might, perhaps, suppose virtue rather than honour to be the end of the political life. But even virtue seems, in itself, to be lacking something, since apparently one can possess virtue even when one is asleep, or inactive throughout one's life, and also when one is suffering terribly or experiencing the greatest misfortunes; and no one would call a person living this kind of life happy, unless he were closely defending a thesis' 1095b

In the controversial and debated topic of remuneration, it is interesting that Aristotle makes reference to monetary gains in his quotes. He states that monetary compensation is not the only means of obtaining value, but he acknowledges that arguments have been made against this.

'The life of making money is a life people are, as it were, forced into, and wealth is clearly not the good we are seeking, since it is merely useful, for getting something else. One would be better off seeing as ends the things mentioned before, because they are valued for themselves. But they do not appear to be ends either, and many arguments have been offered against them' 1096a.

On the topic of the work-life balance including family and social interaction for happiness, there is acknowledgement from Aristotle of this type of life being yet another means of reaching happiness. This would likely be an extension to the life of politics.

‘Happiness in particular is believed to be complete without qualification, since we always choose it for itself and never for the sake of anything else. Honour, pleasure, intellect, and every virtue we do indeed choose for themselves...but we choose them also for the sake of happiness, on the assumption that through them we shall live a life of happiness; The same conclusion seems to follow from considering self-sufficiency, since the complete good is thought to be self-sufficient. We are applying the term ‘self-sufficient’ not to a person on his own, living a solitary life, but to a person living alongside his parents, children, wife and friends and fellow-citizens generally, since a human being is by nature a social being’ NE1097b.

Aristotle speaks of happiness and the work of the soul and believes that the political science is held in the highest esteem. In addition to understanding the body, the activity of the soul is the added element that leads to reason, wisdom and happiness.

‘Clearly it is human virtue we must consider, since we were looking for human good and human happiness. By human virtue, we mean that of the soul, not that of the body; and happiness we speak of as an activity of the soul. If this is right, the politician clearly must have some understanding of the sphere of the soul, as the person who is to attend to eyes must have some understanding of the whole body; more so, indeed, in that political science is superior to medicine, and held in higher esteem, and even among doctors, the sophisticated ones go to a great deal of effort to understand the body. The politician, then,

must consider the soul, and consider it with a view to understanding virtue, just to the extent that is required by the inquiry, because attaining a higher degree of precision is perhaps too much trouble for his current purpose ' NE1102a.

The above passages have addressed honour, truthfulness, friendship, and I have attempted to exemplify how these passages can apply to today's virtue-based medical field and physician-patient relationship. In addition, application of these virtues is seen by Aristotle as the path to political involvement, which he terms political telos, and eudaimonia, otherwise known as happiness. Virtue-based medicine, therefore, has a greater chance of leading to physician political involvement, and thereby, happiness in the community. From the physician's perspective, this is an important extension from the traditional one-on-one role in the physician-patient relationship.

In order to understand the connection of wisdom and involvement in the polis, it is important to first understand the three relevant factors that lead to the citizen of the polis becoming virtuous according to Aristotle. These are:

1. Nature
2. Habit
3. Reason

Nature refers to development through genesis: 'to start with, one must be born with the nature of a human being 'Politics1332a. Secondly, the *oikos*, is the home, where habits are imposed on the qualities the human child is born with early ethical training (NE1179b). The given qualities are changed into virtuous habits through training in the appropriate environment. Finally, 'human beings live by reason also' Politics1332b; reason is the distinguishing mark of the human, and the *polis* sets the soil for reason. Nature, habit and reason must be in harmony in human beings.

Reason must be trained, and Aristotle pursues the question of what that training should be in Politics books VII and VIII. In Politics VIII he refers to the active life as being the best for both the state as a whole community and for the individual. Aristotle's view is that happiness is a form of activity and man cannot be happy if he is not active. The concept of happiness follows Aristotle's previous discussion in the *Nicomachean Ethics*. He now further explains that education should be directed to the needs connected with one's role in adult life, especially the needs of statesmen and citizens; in this state, all citizens will share, in turn in ruling and being ruled, therefore, a single plan of education, shared by all citizens' children as potential rulers is appropriate; haphazard education is not conducive to the unity of the polis Politics1337a; Aristotle seeks to minimize the impact of randomness through a single educational program and since best communities and best individual share the same goals (temperance, justice, courage, love of wisdom), the lawgivers work of establishing such schooling will have a common, unified benefit for both the polis as a whole and its individual citizens.

This view of education and training is an important element that could be applied to the professionalism in medicine. I will demonstrate this more clearly in the text that follows. Starting with medical education, standards can be met consistently through programs encompassing the elements of a body of knowledge. Following graduation, the professional maintains competency through ongoing professional development and training within the scope of their practice. The development of a professional identity, through teaching of sentinel events in medicine, and dealing with professional lapses, looks to develop a behavioral response. Exposure to multiple stressors and opposing priorities is seen as a means of becoming a physician, as opposed to the initial ephemeral stage of doing the work of a physician (Olive and Abercrombie 101). Teaching

leadership skills to medical residents includes the nontraditional skills, such as how to engage in self-reflection, cultivate self-awareness and the capacity for self-regulation, lead teams and practice followership (Blumenthal, Bernard, Bohnen, and Bohmer 518). Although the teaching of skills begins in medical school, the experiences throughout medical school, and then throughout the physician's career surmount to reaching a practical wisdom in the field. This wisdom contributes to development of the professional identity.

Aristotle speaks of practical wisdom, that is, a grasp of 'practical truth' independent of what we think. He makes the distinction from 'judgment', which is 'concerned not with what is eternal and unchanging, nor with what comes into being, but with what someone might puzzle and deliberate about', and therefore 'is concerned with the same things as practical wisdom' NE 1143a. The beneficial state of practical wisdom is achieved through training and experience; it takes time to learn the rules and the policies, and then practical analysis and wisdom to learn to apply them correctly.

'Practical wisdom (*phronesis*) gives commands, since its end is what should or should not be done, while judgment only judges'.

'We may grasp what practical wisdom is by considering the sort of people we describe as practically wise. It seems to be characteristic of the practically wise person to be able to deliberate nobly about what is good and beneficial for himself, not in particular respects, such as what conduces to health or strength, but about what conduces to living well as a whole.'

'An indication of this is the fact that we call people practically wise in some particular respect whenever they calculate well to promote some good end that lies outside the

ambit of a skill; so where living well as a whole is concerned, the person capable of deliberation (long and careful consideration or discussion) will also be practically wise' NE 1140a.

Therefore, simply to know the rules is insufficient. The rules are then applied, responsibly, to practical situations, after discussion and thought, and it takes time to acquire this, as Aristotle calls it, moral knowledge (Van Niekerk and Nortjé 30).

'It remains therefore that it is a true and practical state involving reason, concerned with what is good and bad for a human being. For while production has an end distinct from itself, this could not be so with action, since the end here is acting well itself. This is why we think Pericles and people like him are practically wise, because they can see what is good for themselves and what is good for people in general; and we consider household managers and politicians to be like this'.

'Practical wisdom, then, must be a true state involving reason, concerned with action in relation to human goods' NE1140b.

'The reason is that practical wisdom is concerned also with particular facts, and particulars come to be known from experience; and a young person is not experienced, since experience takes a long time to produce' NE1142a.

When we speak of physician assuming a political role, and one of leadership in their community, the question that arises is, can leadership be learned? It is hoped that leadership capabilities such as emotional intelligence, relationship building, inter-professional teamwork, large-scale systemic change, organic systems thinking, and coalition building may have been self-learned by physicians (Van Aerde and Dickson 15). And mastering these capabilities requires a

mindset and combination of knowledge and skill. Since not all physicians, will have acquired these skills, these can be compared to Aristotle's *reason*, which is acquired through training. This is in keeping with providing physicians with the opportunity to develop the appropriate skills, as early as in the medical school curriculum. 'Leaders are both born and made' (Van Aerde and Dickson 17). Leaders are born with certain talents, and these may be developed further by acquiring knowledge and learning the skills.

Michael Porter and Elizabeth Teisberg, in their article "How Physicians can change the Future of Health Care", acknowledge today's preoccupation with cost shifting and cost reduction in the United States, instead of the focus being on health improvement and health care value with an overall improvement for patients (1110). They enlist physician leadership to lead this change, as they are in a position to return the practice of medicine back to effective health care. By reaffirming the importance of value for patients, and organizing medical care around medical conditions, and providing risk-adjusted outcome and costs, professional satisfaction will also increase, and pressures on physicians will decrease. 'If physicians fail to lead these changes, they will inevitably face ever-increasing administrative control on medicine. Value-based competition on results provides a path for reform that recognizes the role of health professionals at the heart of the system' (Porter and Teisberg 1103). The pursuit of excellence and therefore value-based medicine is thought to provide the following improvements to health care: 1. The performance of each physician will improve, since the physician is providing a service in which he/she is trained and excels 2. There will be more medical conditions addressed and more patients treated and 3. The overall value of patient care will improve; In addition to these, I would add 4. Empowerment and raised morale in physicians with overall improved physician health and well-being; this is again

contributing to improved value of patient care. It makes sense that a physician who focuses on value of health care services, and who is free to have this factor as a work priority, will seek to collaborate more with other physicians and health care professionals. The focus is not on self-contained practices, but on providing the best care to the patient. This return to value-based medicine in essence, is a return to virtue-based medicine as supported by Pellegrino and others.

The envisioned consequence is that patients will become engaged participants in their care, thereby adhere to their treatments, and act responsibly, rather than passively accepting changes to their care. Active participation may mean more satisfaction with health care, in a system where patients are able to trust the system and make informed choices, and where their autonomy is respected and their care is valued.

But what of the physician making recommendations of cost benefit? According to Russell L. Gruen, Steven D. Pearson, and Troyen A. Brennan, there are compelling reasons to urge for greater engagement of physicians in the public arena, including physicians' expertise being essential for properly addressing major quality, access, public health and policy concerns (94). Clear and visible leadership for the good of the public, may be the best way to regain the public trust that has diminished in the last decades. The roles must be clearly defined, and compatible with busy medical practices. With the idea of the professional relationship being a type of social contract between physicians and society, the physician is expected to promote society's health. Physicians can provide recommendations on various factors including biological aspects of disease, and the effects on social, environmental and economic relationships depending on the physician's type of practice and experience. A model has been proposed in which the roles considered as Professional Obligations include Individual Patient Care, and most likely, Access to Care, and Direct

Socioeconomic Influences. The areas of Broad Socioeconomic Influences and Global Health Influences are potential aspirations, for which physicians become more versed as they engage in ongoing dialogue with society (Gruen, Pearson and Brennan 95). Adopting such a framework could assist the physician to develop competence in public roles and professional obligations. Each physician should choose activities that are consistent with his or her expertise, interests and situation. To be effective in these roles, physicians need to become skilled in advocacy and public participation. Physicians are thought to be natural advocates because of their knowledge of health issues their public influence. A role of advocacy, even involving writing letters, or talking to people about pressing health issues to modify opinions is considered a political activity. Examples of advocacy in and outside regular practice settings may include working with others to improve institutional systems of care, or to solve a health problem in the community, or serving in a local organization or political interest group (Gruen, Pearson and Brennan 97). Most public roles are not reimbursed directly, but can be seen as being related to patient care. Public roles can be compatible with medical practice and in the interests of patients, physicians, and society (Gruen, Pearson and Brennan 98).

Professionalism has been described as serving the basis of medicine's relationship with society. According to Richard and Sylvia Cruess this relationship is best termed a *social contract* (2008 580). This mutual state of dependency and obligation is based on society having granted medicine autonomy in practice, a monopoly over the use of its knowledge base, the privilege of self-regulation, and rewards, both financial and nonfinancial. In keeping with the contractual nature of the relationship to society, physicians are expected to put the patient's interest above their own, assure competence through self-regulation, demonstrate morality and integrity,

address issues of societal concern and be devoted to the public good. This contract is a solution to dealing with changes in the last decade that have led to increased dissatisfaction with the present health care. The Hippocratic Oath and codes of ethics of various provincial associations are said to also constitute an explicit part of the contract, as they reaffirm medicine's commitment. This social contract has become the moral basis of professionalism (Cruess and Cruess 2008 580-581).

In keeping with the view of Pellegrino, according to Herbert M. Swick, Charles S. Bryan, and Lawrence D. Longo (263), medical professionalism should reflect the values of a virtue-based ethic. The authors in this paper refer to the Medical Professionalism Project, also known as the Physician Charter, which was created in 2002 in the United States in a collaborative effort of two professional societies in the United States and one in Europe, to address the threats to medical professionalism. Factors driving the renewed interest in professionalism included loss of meaning among physicians who felt 'besieged by the intrusions of government, business and other external forces of changes' (Swick, Bryan, and Longo 264). Traditionally, a profession must meet several criteria, including work that is intellectual with the application of a body of knowledge, public recognition of being able to oversee and regulate practice standards, and commitment to service, however, there are also moral and ethical dimensions to consider. With respect to the public, 'civic professionalism' refers to professional work having public value and needing to serve public welfare. Medical professionalism has been seen as a means to address challenges not only involving individual patients, but also society and the global community. Swick, Bryan and Longo draw attention to the fact that the profession of medicine is set apart from many other occupations in that many others do not have the moral imperative and the ethos of public responsibility, nor do many of the other occupations demand the high level of service

transcending personal gain of true professionalism. Some of the criticisms of the Charter stem from an emphasis on patient autonomy where less importance is given to physicians' social roles and responsibilities. In other words, the Charter is seen as having more of a Deontological and duty-based ethic and departure from Virtue-based ethics. This contract, written in the third person with use of legalistic terms, may be seen as implying distrust in the relationship between physicians and patients, or society. Moreover, by providing a contract, or letter of agreement, physicians may follow the minimal ethical requirements, as dictated by the contract. This is in contrast to a Medical oath, which is written in the first person, and is seen as a promise reinforcing the view of physicians seen as a moral community. This is in keeping with Pellegrino's discussion, who is quoted in this article, 'to erase the principles of the medical oath entirely from our consciousness would be to make medicine no more than a commercial, industrial or proletarian enterprise' (Swick, Bryan and Longo 267-268). 'The purpose of the oath would be to establish the moral framework and the healing imperative by which the challenge of medical practice can be more effectively addressed' (Swick, Bryan and Longo 268). In other words, the purpose of the oath is to remind and reinforce the virtues central to medicine, these being compassion and beneficence. The Oath is recited in the first person, and a personal commitment, or promise, to the profession. By feeling a genuine commitment to the values of the oath, and thereby to the patient and society, the physician is not constrained by the minimum standards of a contract. Although a literal application of the Hippocratic Oath is nonsensical, an adherence to the principles and values inherent in the Hippocratic Oath continues to be relevant. 'The purpose of medical oaths is to assist in inspiring and preserving the finest tradition of medicine as a healing profession. Statements of medical professionalism, whatever their origin, should not only

articulate clearly the principles and values of the profession but also maintain and burnish the long and noble heritage found in the joy of healing' (Swick, Bryan and Longo 269). The Charter is devoid of words such as sympathy, self-sacrifice, devotion or calling, but the broader social roles and responsibilities are acknowledged. Physicians retaining and enhancing their professionalism by assuming larger roles in the health of disadvantaged persons and professionalism is an important way in which medicine can speak with a more unified voice. The bioethics movement is seen as having more emphasis on a rights or duty-based ethic, with emphasis on patient autonomy, whereas, physicians' traditional values are grounded in a virtue or character based ethic. Principlism includes beneficence and autonomy, but does not mention caring and compassion. Beneficence, compassion and altruism exemplify the higher values of medicine and are grounded in a virtue-based ethic. A contract or charter reflects primarily a duty-based ethic, chiefly concerned with physician competence. Compassion, meaning 'to suffer with', is integral to the practice of medicine. Beneficence, meaning 'well-doing', active kindness, distinguishes medicine from other professions.

Distinctions are described in types of professionalism, which may exemplify the virtue-based ethics applicable to the medical profession. *Basic professionalism* which is described as doing the right thing, can be claimed by many professions, but is not the same as *higher professionalism*, which is service that clearly transcends self-interest; this is the hallmark of medical professionalism because physicians are called upon to subordinate their own interests. *Higher professionalism* follows the Virtue based ethical framework, unlike *basic professionalism*, which follows the rights and duty-based framework (Swick, Bryan and Longo 271). This 1973 quote

by Goodfield, in the same article, reaffirms the need to resetting the moral compass towards love of the profession:

‘It may be that until we manage to recover love of the art and love of people, as opposed to love of the technique, or love of the affluence, or love of the status, as the real motivation for entering medicine, we may not get a satisfactory ethical relationship between doctors and society’ (Swick, Bryan and Longo 273).

The profession must move beyond the Charter’s somewhat narrow focus on duty and competence to embrace the ideals, the genuine sense of selfless service and the deep commitment to patients that have for so long epitomized the highest values of medicine. According to William Osler, Canadian physician and first Professor of Medicine at John Hopkins University, ‘the practice of medicine is not a business and can never be one...our fellow creatures cannot be dealt with as a man deals in corn and coal; the human heart by which we live must control our professional relations’. This is a quote from Osler from 1903 (Swick, Bryan, and Longo 270). And, what follows is a quote by Osler from 1903, in which he rejects medicine being seen as a business, and reminds us of maintaining the love of the profession.

‘You are in this profession as a calling, not a business, as a calling which exacts from you at every turn self-sacrifice, devotion, love, and tenderness to your fellow men. Once you get down to a purely business level, your influence is gone and the true light of your life is dimmed’ (Swick, Bryan, and Longo, 270).

Drs. Richard and Sylvia Cruess have become leaders in the field of medical professionalism. They describe the role of the physician as overlapping between that of the healer and that of the professional. Within this model, both positions are necessary to appreciate key attributes of the

physician. Although the primary role of the physician is undoubtedly that of the healer, one must simultaneously maintain professionalism in medical practice. In 2014, Cruess and Cruess wrote about updating the Hippocratic Oath to include medicine's social contract. They stated that the Hippocratic Oath's purpose includes the commitment of the new graduate as to medicine's traditional values, meeting obligations expected of a doctor, and allowing the graduate to take part in a symbolic ritual in professional identity formation. Expectations of the medical profession include those to the patient and to a wider society. They suggest that the Hippocratic Oath be updated to 'better reflect the obligations of both individual doctors and the medical profession to society' (2014 95).

The Canadian Society for Physician Leaders (CSPL) has recently written on Physician Leadership in Canada. Colleagues of physicians who wish to take on leadership and possibly political roles may be seen as abandoning their practices and their patients, and may be criticized and not supported by physician colleagues. Efficient and effective reform of Canada's health care system would involve physicians working with others to change the structural, cultural and political environment. The challenges identified include mindset challenges, and often these involve physicians' own views of leadership (Van Aerde and Dickson 21).

Challenges may be encountered upon collaboration on particular leadership directions, as this will likely involve different mindset of system managers, administrators, and other professions, as well as other stakeholders. There will be educational challenges since physicians do not routinely receive education on leadership roles, and such opportunities are limited. Recommendations for physicians in order to improve leadership include exploration of such roles, with a willingness to participate and encourage efforts from colleagues. Opportunities may arise

to participate in health care reforms, involving quality improvement and patient safety initiatives, for which physicians are well suited and therefore should be encouraged to participate. Physician participation may be required at the university or health research levels in order to provide further evidence based studies on the effectiveness of physician leadership for health benefits to society (Van Aerde and Dickson 19–21). Amanda H. Goodall examined physician leaders and hospital performance in one such study and both hospital ranks and patient outcomes were higher when the CEO's were physicians (538). Provincial and federal organizations, in addition to private associations are enlisted in the White paper prepared by the CSPL, in order to provide support, in the form of education and funding to physicians who are suited for these roles (Van Aerde and Dickson 20).

According to the Canadian Medical Protective Association, 'physicians have a responsibility to contribute to the deliberations that will lead to a transformed healthcare system. This responsibility reflects the profession's obligation to its patients and to society as a whole. Constructive engagement, a willingness to put societal needs above those of individuals or the profession, and a solutions-oriented approach will reinforce the trust that Canadians continue to have in doctors' ("CMPA - Medical Professionalism — What the Future Holds"). As Sullivan reiterates in his article, 'Medicine depends on more than competence and expertise, essential as these are. It cannot function as an institution without good faith on the part of provider, patient and the public as a whole. The root of the public's trust is the confidence that physicians will put patients' welfare ahead of all other considerations, even the patients' momentary wishes or the physicians' monetary gain. It is the function of medicine as a profession to safeguard and promote this trust in the society at large' (Sullivan 675). Sullivan recommends that medicine take the lead

in discussing a contract with society, and that this will promote trust and reengagement of the public in the value of their work, and the ethos of medicine and the larger common good.

I argue that there is more than obligation and responsibility, both which are of paramount importance, but both cannot stand without a foundation of virtue-ethics based medicine. The social contract addresses the professional issues that have grown over the years to make the physician-patient relationship more complex. This support needs to exist so that the intricacies are addressed and do not hinder the care to patients and to society. But, with what moral mindedness? Is it to be assumed that the morality exists, will appear, or be nurtured in the at times competitive environments where physicians work? The missing element, of fundamental importance is the highlighting of virtue, caring and compassion. If advocacy and political involvement are born out of duty, the product will not be as effective, nor interesting. If they are born out of a will to do good and make a difference to society, that is appealing to the nature of the physician to be valued while providing the needed tools and a clear path. As a first step, the Hippocratic Oath needs clearer interpretation to exemplify political involvement. Miles has provided an example of a teaching chart to this effect, which can be adjusted, depending on the priorities of the specific medical school. Consideration could be given to a pre-oath course for preparation, with reference to Aristotelian ethics, Kantian and Utilitarian, in addition to Bioethics and Casuistry based teaching.

b. Benjamin Constant's view on Political Liberty

In the following section, I will use Benjamin Constant's view to support the opinion of physicians' political involvement. Constant, in 1819, in his lecture titled "The Liberty of the

Ancients Compared with that of the Moderns”, questioned the idea of liberty of the moderns whom he did not see as having political liberty. Political liberty is the ability to collaborate and provide societal leadership, comparable to the physicians’ pursuing of political involvement. Liberty of the ancients referred to liberty as per the ancient cities of Sparta, and Rome, whose citizens believed in political liberty, where the individual is considered sovereign in public affairs but a slave in private relations. The city of Athens is the exception in the ancient world, since by being engaged in trade, Athens allowed its citizens more individual liberty; these were elements of modern liberty within the ancient liberty framework. Constant contrasts to this the liberty of the moderns, where the modern citizens of the 19th century did not consider liberty to be active participation in collective power, but rather, peaceful enjoyment of private independence where the will of each individual has real influence, and gives pleasure. The Ancients sacrificed independence to keep political rights, therefore sacrificed less to obtain more. Constant states that the danger of modern liberty is that we, absorbed in the enjoyment of our private independence, might surrender too easily our right to share in political power. ‘We must not leave it to them...’ (‘them’ being the holders of authority)

c. Through the lens of the Hippocratic Oath

As discussed in the previous section,

‘The purpose of medical oaths is to assist in inspiring and preserving the finest tradition of medicine as a healing profession. Statements of medical professionalism, whatever their origin, should not only articulate clearly the principles and values of the profession but also maintain and burnish the long and noble heritage found in the joy of healing’ (Swick, Bryan, and Longo 269).

The application of the Hippocratic Oath to the medical profession is not immediately evident outside of the individual doctor-patient relationship, however, in order to have an effective value or virtue-based system, it is clear that the physician portrayed in the Hippocratic Oath has an obligation not only to his or her patient but to society (Cruess and Cruess 2014 98).

In Miles' book "The Hippocratic Oath and the Ethics of Medicine", he argues that a personal isolation from a sense of civic duty would have been an unusual claim for citizens of Greek city-states. At that time, physicians may have accepted diplomatic missions with the understanding that the physician-citizenship role promoted the health of the citizens of the city-state (Miles 55). This concept, although not clear in the Hippocratic oath, is in keeping with the Aristotelian view of participation in the '*Polis*' as being the ultimate goal of eudaimonia, as seen in the quote 'while the good of an individual is a desirable thing, what is good for a people or for cities is a nobler and more godlike thing' NE1094b.

The public's expectations are, at the minimum, that they are provided with quality health care, and that this care is accessible and equitable. The government is expected to provide the resources to ensure this, at the lowest cost without compromising the care. As per Cruess and Cruess, 'the nature of the social contract between medicine and society imposes limits on the legal contracts outlining the obligation of practitioners, the commercial sector and government. When the limits are exceeded, the public will react' (Cruess and Cruess 2008 587). This reaction of the public may either be in favour of physicians or not, however they will most certainly react when the ultimate result is compromise in their health care. There are additional pressures from the point of view of the physician, as we have outlined in the factors complicating the physician-patient relationship. Physicians seek a more balanced life style and argue for more time and tools

to perform their duties diligently and effectively, with ultimate result being an overall improvement in health care.

I argue for the maintenance of the Hippocratic Oath recital as a means of concretizing the physicians' virtue-based ethics in their profession. The ensuing social contract and codes of ethics are much needed for medical professionalism, as they clearly establish the legal and regulatory framework in the very complicated field of medicine and the much more complex physician-patient, or physician-society relationship. The interconnections between physicians and society are many, and include applicability of federal and provincial laws. These laws need to be readily available, with interpretations to possible applicable scenarios written out easily obtainable, as is most often already the case. However, the aim for the 'good' must be at the foundation of these professional interconnections, and not potentially lost in the trees and branches of legislation and policy. By pledging for the good at the time of graduation, the message will be reinforced in the upcoming years of professional life, in the midst of changing laws, policies, practices or other factors that contribute to the dynamic nature of the doctor-patient relationship.

The reason for maintaining the oath and concretizing the good at the basis of the relationship is ultimately, for the direct good of the patients. However, the good of the patients is further exemplified by factors that maintain the morale and health of the doctor, since healthier doctors mean healthier patients. I argue that if a physician acquires the additional leadership training, then a political role within their expertise is a natural progression. For the virtuous physician who seeks reward by being valued by society, this role in providing evidence-based advice on a policy or political level, albeit challenging, would contribute to physician overall wellness and good health. As discussed previously, factors which increase the risk of burnout in

the physician include intrinsic personality factors, as well as extrinsic factors. These include increased responsibilities and expectations, lack of community support and incongruence of personal values when health care professionals' values are not aligned with the values of the health care organizations with which they're working. These factors are considered to be on the continuum from job burnout to work engagement. Therefore, involvement in leadership and having a direct influence on the organization's values would push the physician towards the work engagement continuum and further from the burnout spectrum. The flip side, a disillusioned or unchallenged physician, one who is clearly capable of contributing further to bettering of society, but who has lost the motivation to do so, may lead to any of the previously mentioned demises. This quotation by Aristotle addresses cleverness in people, and how it can lead to favorable or negative consequences, depending on the objective:

'There is a capacity that people call cleverness. This is such as to be able to do the actions that tend towards the aims we have set before ourselves, and to achieve it. If the aim is noble, then the cleverness is praiseworthy; if it is bad, then it is villainy. This is why both practically wise and villainous people are called clever' NE1144a.

'So there are two states, cleverness and practical wisdom, in the part of the soul related to belief, so there are two in the part related to character-natural virtue and real virtue; and of these real virtue does not develop without practical wisdom' NE1144b.

The compulsive nature of the physician may assist the development of cleverness and the seeking of business ventures and other opportunities. This may be the easier of two paths, when physicians feel that they do not have a purpose in their work and that their personality strengths are not put to 'good' use. They may take the paths where the ethics of medicine become second

nature, such as substance abuse and the life of deceitful behavior that follows (“Barrie ER doctor a ‘slave’ to Fentanyl addiction”).

Although there are many other factors that play a part in individuals who fall victims to addictions, physicians have additional risk factors, as seen above that predispose them to this and other medical conditions.

In those physicians who have had a virtuous upbringing as per Aristotle, the *oikos* is the home, where habits are imposed on the qualities the human child is born with early ethical training (NE1179b). The given qualities are changed into virtuous habits through training in the appropriate environment. The backbone of the message can be instilled with the support of Virtue ethics and the Hippocratic Oath. Reinforcement then occurs through training in leadership and other professional duties, reminding doctors of their obligation to the patient, to their community and to society. The *polis* sets the soil for reason, and the contribution of society and the community leads to ‘reason’. The idea that their contribution would be valued by society would reinforce their comprehension of the value in their role. Again, the above refers to a virtue-based medical practice, and the ethically minded, virtuous physician who is seeking happiness and practical wisdom towards the *telos* or *eudaimonia*. It may be possible that a physician has not developed ethical capacity, therefore, the message of the Hippocratic Oath and Virtue ethics would not be fully applied. Thought may be given to providing a course in main ethical theories in Philosophy, encompassing the Virtue ethics, Deontological and Utilitarian ethics in addition to the ethics of Principlism, in order to better understand the oath, prepare for recital and graduation, and the training and challenges of the medical field. Ultimately this preparation and experience in the field, while maintaining professional standards and virtues, will prepare for an eventual role in

community or political contribution.

7. Conclusion

The community's needs, expectations and approval are the common objectives of all morally minded citizens; this is what leads to happiness and a good life for everyone. The physician is in a position to contribute to community happiness, by having an impact directly on individuals and indirectly on society as a whole, as in the public health and public safety settings. As one step further, this impact may be even stronger should some physicians seek to project their leadership and medical skills and knowledge in the political sphere. As per Aristotle's *Nicomachean Ethics*, the ultimate reward comes with using experience and knowledge for the betterment of the community and in leading fellow citizens virtuously. This reward is best obtained in a setting where the intentions for more political involvement are for virtuous reasons, and in which the physician has acquired the knowledge and experience to perform the duties. The Hippocratic Oath, along with other tools, provides the means to solve these ethical dilemmas that may arise.

It is expected and hoped that physicians who enter the field of medicine do so with a goal of beneficence and in search of positive moral rewards, either at the individual or societal level. The Hippocratic Oath, with improved preparation, interpretation, possible amendment and better communication, may be a tool to physicians to see themselves as not only part of the individual patient's care, the public health field, and also the general community and thereby to maintain the desired moral recognition that keeps them in practice and empowered.

With today's statistics of physician dissatisfaction and burnout of physicians, increased substance abuse and suicide rates, addressing physician well-being is of paramount importance. There is a definite value to contributing to physician health. Healthier physicians mean healthier patients.

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