



**Can Virtues be taught in Medicine? Aristotle's Virtue Theory and  
Medical Education and Clinical Practice**  
**As Virtudes podem ser ensinadas em Medicina? Teoria Aristotélica das  
Virtudes, Educação Médica e Prática Clínica**

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**Abstract:** In a complex and technologically sophisticated healthcare system, the utilization of virtues, which emphasizes the art of clinical practice, is often eclipsed by the technical science of its practice. Consequently, the training of physicians generally focuses on the objective and quantifiable science of clinical practice, which at times cripples the patient-physician relationship. To counter this impact on the patient-physician relationship, medical educators are developing pedagogical strategies to teach virtues to medical students and residents. But, can virtues be taught in medical school or in the clinic? To address this question, we explore how Aristotelian virtue theory can be integrated into the medical education experience, which leads to the formation of virtuous physicians. We then conclude by discussing issues surrounding the incorporation of virtues into the medical curriculum.

**Resumo:** Num sistema de saúde complexo e sofisticado tecnologicamente, a utilização das virtudes, que enfatizam a arte da prática clínica, é frequentemente eclipsada pela sua ciência técnica. Consequentemente, o treino dos médicos geralmente é centrado no objetivo e na ciência quantificável da prática clínica, o que às vezes torna deficiente a relação médico-paciente. Para contrapor esse impacto sobre a relação médico-paciente, educadores médicos desenvolvem estratégias pedagógicas para o ensino das virtudes aos estudantes de medicina e residentes. Mas as virtudes poderiam ser ensinadas nas escolas médias ou nas clínicas? Para tratar desta questão, exploramos como a teoria das virtudes aristotélica pode ser integrada na experiência educacional em medicina, o que nos leva à formação de médicos virtuosos. Concluímos ao discutir questões acerca da incorporação das virtudes no currículo médico.

**Keywords:** Aristotle, Clinical practice, Medical education, Virtues.

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## I. Introduction

New goals of a revolutionary sort are taking shape in medical schools. Concerned over the narrow technical training of medical students and their lack of preparation to face the complex challenges of contemporary medicine, medical schools, in an astonishing burst of reform within the past decade or so, have developed new curricular strategies to balance and complement, with medical humanism, the traditional emphasis on the technical sciences.<sup>2</sup> These curricular efforts emphasize practical approaches to such topics as medical ethics, patient narratives, religion and spirituality, and death and dying, in order to improve the student's understanding of the ethical, humanistic, and spiritual dimensions of the patient-physician relationship.

To date, medical school courses and curricula categorize the art of clinical practice as a loosely organized and undefined medical discipline, as exemplified by such terms as medical humanism, professionalism in medicine, humanities and medicine, and medical ethics—often being used interchangeably. What to call this emerging discipline is a pressing problem. Moreover, so are its goals and unifying principles, particularly as it attempts to guide medical students and

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<sup>2</sup> MEDICAL SCHOOL OBJECTIVES WRITING GROUP. Learning Objectives for Medical Student Education—Guidelines for Medical Schools: Report I of the Medical School Objectives Project. *Acad Med.*, 74, 2009, p. 13-18.



residents to become good doctors. In response, we argue that medical educators must teach the virtues relevant to clinical practice to medical students and residents, in order to realize a robust medical humanism.

Patients certainly appreciate and expect technical competence in physicians. Grounded in the perceived ideal of the good doctor, this trait exemplifies an important goal of the medical profession. Most medical educators would also include the civil virtues, i.e. virtues that transcend most cultural value differences. These virtues include such traits as respect, compassion, and honesty, and they are fundamental to any morality that professional medical caregivers are expected to embrace. These fundamental virtues facilitate the transformation of a good doctor to the status of a virtuous one.<sup>3</sup>

An important question for integrating virtue into the medical curriculum and clinical practice is how to conceptualize virtue. Unfortunately, virtue signifies many different things, especially since the term originates from and is chiefly associated with moral and religious traditions. Virtue is commonly viewed as morally presumptuous, as it may connote the imposition of an ultimate ethical standard. For example, it is defined as ‘conformity to a standard of right’.<sup>4</sup> Alternatively, medical scholars and practitioners have turned to existential

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<sup>3</sup> PELLEGRINO, Edmund D.; THOMASMA, D. C. *For the Patient's Good*. New York: Oxford University Press, 1988.

<sup>4</sup> SYKES, J. ‘Virtue’. In: *The Concise Oxford dictionary of current English*: Based on the Oxford English dictionary and its supplements. 6th ed. Oxford, Eng.: Clarendon Press, 1976.



philosophy, Judeo-Christian theology, Kantian moral imperatives, psychoanalytic theory, or literary models—to assist in articulating the nature of virtue robust enough to guide the teaching of medicine and its practice.<sup>5</sup>

Which of the above alternatives for defining virtue should be used to teach contemporary medical students and residents? The answer to this question must take into consideration the complexity involved in proposing a virtue-based approach to medical education within a postmodern era shaped by the failed attempt of the Enlightenment to ground morality on a universally rational basis. Some scholars claim we are left without any objective procedures to demarcate between what is right and wrong.<sup>6</sup> In addition, the rise of a powerful individualism in Western society, especially in the United States during the past two centuries, has resulted in the abandonment of individuals to their own resources for moral authority. Human freedom and liberty imply that individuals have the right to exercise their own discretion about how to act and live. Clearly, no single moral principle or religious commandment or dogma can provide the substantive basis for right action in such a social milieu. In a profession that prizes individualism, medical educators are often expected simply to assume that students can improvise with respect to their own professional and moral

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<sup>5</sup> MACINTYRE, Alastair. *After Virtue*. 2<sup>a</sup> ed. Notre Dame, IN: University of Notre Dame Press, 1984; PELLEGRINO, Edmund D.; THOMASMA, D. C. *The Virtues in Medical Practice*. New York: Oxford University Press, 1993; PELLEGRINO, Edmund D.; THOMASMA, D. C. *The Christian Virtues in Medical Practice*. Washington, DC: Georgetown University Press, 1996; MARCUM, James A. *The Virtuous Physician*. New York: Springer Press, 2012.

<sup>6</sup> See, for example, ROM, R. *Contingency, Irony and Solidarity*. Cambridge, U.K.: Cambridge University Press, 1989.



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identity and integrity, as well as in terms of personal standards (even when historical and contemporary evidence demonstrates otherwise).<sup>7</sup>

For most of the twentieth century, philosophical ethics in the Anglo-American tradition focused on meta-ethics, or the analysis and clarification of ethical terms, and attempted to provide a theoretical justification of right action. Moreover, the rise of bioethics during the past several decades has returned healthcare professionals to the everyday world by assisting them to grapple with problems that require concrete resolution. Bioethics has provided a bridge between philosophical forms of moral assessment and the messy domain of human actions, particularly in the realms of human illness and clinical decision making. It has also had an impact on medical education by teaching students to think critically about value dilemmas in clinical practice.<sup>8</sup> However, with respect to such ongoing fundamental bioethical conflicts as abortion, physician-assisted suicide, and human cloning, it is clear that philosophical ethics and bioethics within a pluralistic setting do not have the moral force to achieve consensus over a normative standard that would provide definitive resolutions to ethical problems—especially for individual patients. Although modern society’s pluralistic nature seems opposed to a virtue standard, the need for such a

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<sup>7</sup> SHAFER, H. *The American Medical Profession, 1783 to 1850*. New York: Columbia University Press.

<sup>8</sup> SHRYOCK, R. *The Development of Modern Medicine*. New York: Knopf, 1947.



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standard appears to be an important avenue for progress to a greater social good in medicine.<sup>9</sup>

As medical educators continue to develop and implement pedagogy strategies, there is an urgent need for a common language with which to describe the goals of a coherent, collectively understandable moral framework in clinical practice. Generally, patients want physicians to be individuals and to manifest their individual humanity in unique ways, using their own internal resources to apply their medical knowledge compassionately. Yet, there are professional and ethical boundaries within which individuality must manifest itself in medicine. The act of entering the medical profession should require physicians to embrace and manifest certain characteristics indicative of the virtuous physician. So, is there a notion of virtue adequate for contemporary medicine?

## II. The Application of Aristotelian Virtue

The Aristotelian notion of virtue can provide guidance for medical educators. Aristotle held that virtue in general is that which enables people to become what they most essentially are, i.e. virtue is the mark of excellence in function.<sup>10</sup> He believed that a person becomes virtuous by learning the right habits through education and practice. Importantly, virtue does not entail following rules or repeating practiced drills mindlessly and mechanically. A life of virtue stems

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<sup>9</sup> STARR, P. *The Social Transformation of American Medicine*. New Jersey, Princeton University Press, 1984.

<sup>10</sup> ARISTOTLE. *Nicomachean Ethics*. Ostwald M, translator. New York: Macmillan, 1962.



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from a well-developed character, which, in turn, results from having performed virtuous acts in such a way that they become habits. Performing virtuous acts also requires self-awareness and the motivation to act in a virtuous manner—to do the good. Hence, virtue becomes ingrained as a natural way of living and flows from character because a person develops habits based upon observing virtuous role models. A virtuous person reaches a level of internal harmony or integration between cognition and emotion, freedom and adherence to ideals, and individuality and community.

Aristotle's notion of the mean aptly explicates the sense of virtue. Accordingly, virtue is a proper balance between the extremes of deficiency and excess—or vices. For example, courage is the mean between cowardliness and recklessness. By engaging Aristotelian virtue theory, medical educators can equip medical students and residents with traits that can be used to define a general moral framework, so that they can develop their own individual moral styles. The virtuous physician embodies these traits and uses them in caring for patients.

Particular kinds of human activities require specific types of virtues, which Aristotle described as 'states of character'. The person who excels in an activity often demonstrates the virtues or states of character appropriate for that activity. Role models who exemplify and embody the ideal performance for such an activity serve as a standard by which to judge performance and as a template on which to model one's actions. Because human beings simultaneously perform individual and social acts, virtues embodied by individuals reflect both personal and transpersonal or interpersonal ends associated with those acts. For example, because the goal of medicine is to



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relieve suffering by caring for the sick, the virtuous acts of individual physicians promote both their own professional excellence and the capacity of the medical institution to accomplish its. Thus, virtues allow individuals to fulfill both their personal function and the function of the profession in which they participate.

The purpose of this paper, then, is to encourage medical educators to use Aristotle's framework of virtue as a touchstone for accomplishing their goals in training students. To that end, they need to rethink and debate with renewed vigor on what being a virtuous physician entails. This includes several expectations for students. For example, should educators tolerate students who deride the value of learning how to engage in empathetic listening, to appreciate patient narratives, or to develop skills in ethical discernment? And, what about students who believe that such skills are not essential in becoming a good and effective doctor?

Although the above questions have yet to be answered satisfactorily, we argue that Aristotelian virtues provide a standard of virtuous practice to answer them. Specifically, for Aristotle, *phronesis* or practical wisdom serves as the chief virtue to operationalize other virtues. Medical educators then must develop a pedagogical strategy to teach practical wisdom first, such that the technical education and the clinical experience are accompanied by insight into how best to negotiate the clinical encounter. In doing so, students can recognize and appreciate how virtue can help to provide the best possible clinical decision and action.





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To be viable for medical training, a virtue must serve as a unifying principle to articulate and realize the goals of medical practice. Such a concept of virtue in contemporary medical education, as well as clinical practice, must accommodate a pluralistic society in which reasonable people often disagree about how fundamental values apply to certain situations. Therefore, we must recognize that in today's healthcare setting, virtuous physicians do not necessarily have definitive solutions to every fundamental moral quandary. What they need to have are non-negotiable procedural social values, such as respect for equality, freedom, and human rights. In the contemporary healthcare system, these procedural values reflect the capacity and courage to function professionally in an environment in which moral ambiguity is pervasive, to tolerate moral differences and uncertainties in order to develop as thoughtful moral agents, and to respect and understand various cultural traditions. These values, in turn, serve to support the Aristotelian virtues that undergird respect for patient autonomy, beneficence, non-maleficence, compassion, and honesty, which are associated with the virtuous physician.

Finally, these virtues cannot be derived from a set of definitive and specific moral rules that are applicable for every occasion. Rather, they are meant instead to guide physicians in professional interactions with patients. These virtues are at the root of efforts to promote humanism and professionalism within clinical practice. This requires teaching particular skills in such areas as patient assessments, accurate interpretation of illness narratives, and the care of the dying. Thus, medical educators should strive to instill virtues by role modeling them for students so that students develop the necessary humanistic skills to provide quality healthcare.



### **III. Virtue in Action**

Modern medical education is undergoing radical change, particularly in terms of re-instating the art of medicine. As noted above, the American Association of Medical Colleges has taken a leadership role towards this end in its Medical School Objectives Project. Aristotle's virtue theory provides modern medical educators with a strategy by which they can incorporate virtues into the teaching curriculum. But, there is need to think critically about which of the Aristotelian virtues can facilitate this goal, given the diverse range of concrete clinical practices. Importantly, these virtues should be formulated and agreed upon in response to the challenges of medical practice. Specific curricular strategies must then be developed with testable outcome measures. Above all, medical students and residents should be challenged, and provided with the necessary support, to operationalize and realize the standard of excellence virtue requires.

It is unlikely that a single course within the formal medical curriculum is adequate for the task of teaching virtue, since both formal and informal curricula contribute to the development of the student's values, character, and virtues. The goal of teaching virtue then must be understood as an institutional mission, located within and supported by the medical profession, based on formal and strategic curricular innovations and clinical role modeling. This implies that there must be community consensus, which explicitly defines its professional mission, sets a clear and visible standard for those who enter the profession, and is committed to teaching the standard through consistent



modeling. Toward this end, the medical community would benefit from utilizing Aristotelian virtues to achieve its curricular goals. The educator's prime responsibility is to embody and exemplify the habit of virtues in action.

Modern cultural and religious fragmentation is now common throughout the modern world and prevents the establishment of a single, foundational standard of virtue, thus calling for an adaptive way of defining and then teaching virtues. For Aristotle, practical reason or *phronesis* molds behavior by requiring moral agents to act in a way that is appropriate to a given situation, as determined by rational deliberation. If a virtue represents a mean, especially between two extremes or vices, then it is relative to the individual and to the conditions under which a particular action is performed; and it therefore certainly requires careful deliberation. A part of the process of operationalizing the virtues for medical students and residents, is equipping them with the ability to engage in deliberation about the relevance of the virtues to the peculiar and perhaps unique conditions of clinical encounters, especially their moral demands. The morally appropriate and thus virtuous action is always one that takes into account the specifics of a given situation.

Medical education, in terms of moral reasoning skills, is useful for improving the professional responsibility in general performance of clinical practice. For example, Donnie Self found that the clinical performance of students was positively correlated with proficiency in moral reasoning.<sup>11</sup> He also found that

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<sup>11</sup> DONNIE, J. *Self*. Annals of Behavioral Science and Medical Education. Pennsylvania: Wolters Kluwer Press, 2004.



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moral reasoning could be improved through classes in medical ethics and small-group discussions of ethical issues, based on actual clinical scenarios.

Moreover, clinical role modeling can be utilized as a method to train medical students and residents in terms of *phronesis* or the practical reasoning skills and to act virtuously in a given clinical situation. The issue at hand, however, is defining a standard of virtue that guides how a clinical role model might respond to particular clinical scenarios. In a society of cultural and moral fragmentation, it is not practical to expect every role model to share a common moral framework to ground a virtue standard. Each role model would most likely teach under a particular moral framework and respond differently to specific situations. Hence, care must be exercised to ensure that Aristotelian role modeling in virtue relative to the role modeler does not succumb to fragmentation rather than to standardization.

In conclusion, the lack of standardization in virtue does not preclude teaching virtue, but rather places into question the effectiveness of pedagogical methodology and strategy. Modern medical educators must address the question, ‘Can virtue be taught in modern medical education?’ Any attempt to prepare medical students and residents to function as fully competent physicians, trained to care for the patient’s needs, must include virtues. Choosing a robust and effective strategy to achieve this goal is contemporary medicine’s urgent challenge. For not to teach virtues, is to leave the door open for vices.



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