A Return to Virtue

The dominant trend in contemporary medical ethics describes ethical behavior in terms of the principles and rules that must be followed to bring it about, most notably nonmaleficence, beneficence, justice, and respect for autonomy. An alternative approach to ethics, virtue ethics, emphasizes not principles and rules, but rather the virtues, or characteristics, whose exercise will bring about ethical behavior in a person. In 1996, *Academic Emergency Medicine* published ''Virtue in Emergency Medicine,''[1] a project of the Society for Academic Emergency Medicine Ethics Committee. This article sought to supplement principle-based ethics of emergency medicine (EM) with a virtue-based analysis of what is essential to being a good emergency physician (EP). Good not merely in the sense of technical competence, but in the sense of achieving overall excellence in one's role. The paper was written in a timeless way, as the virtues it discusses—prudence, courage, temperance, justice, unconditional positive regard, charity, compassion, trustworthiness, vigilance, agility—represent attributes any EP must have to carry out his or her practice in the best manner. However, even timeless virtues need frequent reappraisal and reinforcement. Therefore, because of its unique value in delineating the core of good ethical practice in our field, *Academic Emergency Medicine* is reprinting this seminal paper in this issue, to return it to the center of the discourse in our specialty. To begin the conversation, in this commentary we reflect on the particular relevance the paper has displayed in the decade or so since it was first published.

Twelve years may seem a bit soon for such a reappraisal, especially when discussing timeless virtues, many of which have been recognized since ancient Greece. However, the past decade has wrought tremendous changes, political, social, and economic, in all aspects of life, including EM. The virtues discussed in the article provide valuable tools for appropriately dealing with many of the unprecedented challenges that have arisen, or been greatly magnified, over the past decade. Understanding how this is so can help us appreciate and utilize the lessons of the article going forward.

THE CHALLENGES

Disaster Planning and Response

On September 11, 2001, the world radically and permanently changed. Terrorist attacks became a truly worldwide reality. Health care providers, especially emergency personnel, have since been charged with preparing for and responding to these man-made threats.[2] In addition to such attacks, recent natural disasters, including hurricanes, tsunamis, earthquakes, and epidemics, have created growing numbers of victims over widespread areas and challenged the resilience of our health care systems. Preparing for disasters such as these, both man-made and natural, has challenged our profession in unprecedented ways. We must have both the practical and the technical tools to face disaster, as well as the strength to face the moral and ethical demands of treating patients under conditions where resources are scarce and there is ongoing danger to our patients and ourselves.

The challenges of dealing with disasters are thus effectively twofold. First, we must participate in the preparation of resources and the development of polices to deal with such disasters. Second, we must prepare ourselves morally and ethically to face the difficult task of reacting appropriately in the face of extreme suffering and peril. The core virtues important for EPs delineated in the accompanying article are fundamental to our ability to prepare for and deal with disasters.

Perhaps the most difficult task in planning for disasters is deciding how scarce resources will be allocated. For example, states have recently begun to develop policies to provide for the allocation of ventilators in a flu pandemic.[3,4] Developing these triage policies requires one to display several virtues. Justice is central to any attempt to distribute resources fairly and must be a universal goal. Prudence, ''the skill . . . of deciding what is important, applying appropriate weight to important facts, integrating information . . . and coming to a reasoned, sound decision,''[1] is indispensable when making any decision of such weight and complexity. Courage, too, will be necessary, as many of the decisions may be unpopular in the eyes of some, particularly those who will be denied access to scarce resources. One must be prepared to withstand these objections. Finally, if planners are trustworthy, demonstrating a commitment to public welfare, society will be more likely to accept a plan.

One's ability to act ethically in the face of overwhelming disaster will only be known if and when that time arrives. It is during these times of severe stress that depth of character is truly tested. To assure that we are prepared for this ordeal, fostering virtuous behavior in ourselves, our colleagues, and our trainees is paramount. Certainly the courage to be exposed to danger by helping people, rather than taking shelter, is an

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absolute prerequisite to delivering emergency care in a disaster. So too temperance, ''grace under pressure, manifested as calm in the face of chaos,''[1] will be necessary to function adequately under these circumstances. Finally, agility, ''being skillful and adept under pressing circumstances,''[1] will allow physicians to adapt to the unexpected and rapidly changing environment of a disaster.

EMERGENCY DEPARTMENT (ED) OVERCROWDING

A less dramatic, but perhaps more pressing challenge that has developed for EPs in the past decade is that of ED overcrowding. Although this may appear to be a perennial problem, the current crisis, in fact, dates to just after the accompanying article's original publication. In 1997, the trend seen in the early 1990s reversed, and the number of ED visits per year in this country began rising, as it has done steadily ever since. Over the same time period, the number of hospitals providing emergency services has decreased annually.[5] These two factors have been among those most directly responsible for the crisis mode most EDs currently find themselves in.[6]

Practicing in an overcrowded ED presents severe challenges to optimal emergency medical practice. Resources are stretched, stress is extraordinarily high, and cognitive limits are reached. The risks of rendering inadequate care, and even treating patients and staff inhumanely (two major failings in an EP), are relatively high. How would the virtuous EP respond to the problem of overcrowding?

The most essential virtue in conditions of overcrowding, necessary for its own sake and for the exercise of other virtues, is temperance. On a day-to-day basis, there is often nothing individual EPs can do about overcrowding in their EDs. They must simply deal with it, retaining their focus on treating the patients who are in front of them, numerous though they are. Without the ability to remain calm under the persistent stress of inadequate resources and tremendous patient demands, one will not be able to render the care one has been trained to provide. One might even find oneself becoming abusive to patients and others.

A second virtue which, if cultivated, will allow one to treat patients as they deserve, regardless of the environment, is that of unconditional positive regard. The virtuous EP ''must approach each patient with recognition of his or her worth as a human being.''[1] Anyone who fully displays this virtue will approach each patient as he or she presents himself or herself, not as part of an overcrowding problem. Indeed, this positive attitude will remain even in the face of a patient irate due to a long wait under unpleasant conditions. The EP will continue to see the value of the human patient displaying human reactions to stress.

The final virtue necessary to succeed in an overcrowded environment is prudence: ''discernment, judiciousness, and proper discrimination.''[1] The unfortunate truth is that when resources are stretched, we cannot provide all of the services and care we would want to. Prudence allows one to distribute limited time and resources in the most fair and appropriate manner.

BUSINESS MODELS IN THE ED

The widespread recent practice of using patient satisfaction surveys (e.g., Press-Gainey scores) and other business-world metrics (e.g., patients seen per hour) to evaluate and reward EPs presents another contemporary challenge to the ethical practice of EM. The incentives these measures provide are often in conflict with patients' interests. For example, patient satisfaction with the ED is often only surveyed in patients discharged from the ED, who are, in general, less sick. This means that to raise one's scores, one should give more time and attention to the less sick patients than to the sicker patients who perhaps require it more. Indeed, any identifiable distinction between those who are surveyed and those who are not, even if it only depended on the first letter of the patients' names, would be problematic, as it could result in certain patients—the surveyed ones—being inappropriately treated better than others.

The pressure to see more patients can also be problematic. Of course, there are other motivations to see patients faster, including the desire to take care of them. However, to the extent that we rush patient encounters to improve productivity or earnings, we act against patients' interests, not giving them the time and attention they deserve.

Although even virtuous EPs have no choice but to be responsive to the market for their services, the virtues they display may help them avoid a disproportionate response to these ultimately economic incentives. Most obviously, those possessing the virtue of charity will not hesitate to donate their time and attention, which in this case truly are money, to any patient who needs it, even if this behavior may not be rewarded by increased patient satisfaction scores or higher productivity ratings. Although the full expression of the virtue of charity goes beyond mere financial donations to the ''effacement of self interest,''[1] financial sacrifice is perhaps the most concrete realization of this virtue.

The virtues of justice and compassion will likewise aid EPs in this area. Justice requires us to give appropriate service to all patients,[1] without bias toward those who can reward us with positive reviews. Likewise, the compassionate physician will give needed care to every patient, regardless of the administrative consequences.

Finally, courage too may be necessary. The challenges presented by the business of medicine rarely require truly substantial sacrifices to allow one to behave as an ethical physician must, and it is reasonable for one to take into account one's own needs when addressing these issues. However, on occasion the demands of the marketplace, whether passed on by hospital or by corporate administrators, may interfere so much with appropriate practice that the ethical physician cannot accommodate them. In such a case, the virtuous EP will need the courage to risk his or her financial well-being and seek another practice environment.

HEALTH CARE DISPARITIES

Continuing disparities in the health care delivered to different populations present modern medicine with

further challenges. Most significantly, patients from minority and disadvantaged backgrounds continue to bear a disproportional burden of disease and receive an inferior quality of care across the spectrum of medical therapy, from acute care, to preventive measures and management of chronic conditions.[7] These disparities contribute to the decreased life expectancy and increased disease-specific morbidity and mortality among African Americans, Hispanics, and other minority groups, even when insurance status, access to health care, and severity of conditions are comparable.[8]

These inequities are present even in the ED. The treatment of ischemic chest pain, ischemic stroke, and pain in the ED demonstrate widespread differential treatment between ethnic groups.[9] Furthermore, in 2006, the Agency for Healthcare Research and Quality's National Healthcare Disparities Report found that quality differentials in the hospital care for pneumonia received by African Americans and whites are worsening, while the hospital treatment of myocardial infarction is worse for Asians and Native Americans when compared to whites.[10] This trend may continue to grow as the under- or un-insured population increases and racial and ethnic minorities and immigrants continue to use the ED disproportionately for all aspects of medical care.[11] The EP therefore bears some personal responsibility for rectifying these inequities and delivering equitable care to all patients, irrespective of background and socioeconomic status.

There are, of course, numerous sources and complex reasons for the observed health care disparities at the systems, patient, and provider levels, but a virtue-based ethic can help the EP provide equitable care to all. A commitment to justice requires the virtuous EP to ''ensure fairness and consistency''[1] when treating patients from divergent backgrounds. The just provider will work to ensure that the same quality of care is provided to all patients, regardless of their backgrounds. Doing so entails educating oneself about the causes of, and remedies for, health care disparities. On the individual level, the virtuous EP should avoid biases that may lead to stereotyping patients based on racial or ethnic characteristics and develop cognitive checks to assure that biases do not effect clinical decisions. The just EP will also work, on a systems level, to support policies that deliver equitable access to health care for all members of society and improve social and living conditions for the impoverished.

Exercising the virtue of charity will also aid EPs in combating disparities. Patients from disadvantaged backgrounds may require accommodations in our clinical practice, demand additional explanations and time to make decisions, or require extra effort from us if they are to achieve the same outcomes as more privileged members of society. By giving more of one's time, effort, and self to these patients, the charitable EP can aid in reducing health care disparities.

ETHNIC DIVERSITY

Delivering care to an increasingly diverse patient population also presents the EP with the challenge of developing a therapeutic patient–doctor relationship and meeting patient needs when the patient and the provider may hold different health care values, come from divergent socioeconomic strata, and speak different languages. These obstacles may be especially acute within the ED where resource limitations, time pressure, and high patient acuity may impact patient care. Nonetheless, the virtuous EP will be equipped to deal with this challenge.

The key to a good patient–doctor relationship is trust. Striving toward the virtue of trustworthiness will thus help the EP partner with patients even under difficult circumstances like these. The degree to which patients trust their physician predicts adherence to treatment, satisfaction with care, and tendency to seek health care in times of need and thereby influences clinical outcomes.[12] Providers can enhance their own trustworthiness by improving their cross-cultural communication skills and developing cultural competence and awareness, thus showing their respect for the patient and allowing them to accommodate and negotiate with patients in a more informed and respectful manner. Improved cultural competence also allows the EP to make more patient-appropriate clinical recommendations. This will not only directly improve care, but will also reinforce the patient's trust, as a patient is likely to have more trust in a doctor whose recommendations seem reasonable and appropriate to the patient. The issue of trust is even more acute in the case of illegal immigrants and undocumented aliens, where, from the patient's perspective, liberty, and not merely health, may be at stake. Unless we can gain their trust, we may be unable to render any care, let alone ideal care, to these patients. The EP should strive to allay the fears of such patients by rendering care and arranging follow-up even when patients may desire not to provide sensitive personal information.

In addition to trustworthiness, the virtue of compassion can help the EP connect with patients from different backgrounds. Adapting one's practice to be sensitive to the gendered provider needs of an Orthodox Jew or Muslim, providing interpreters for patients, or allowing patients to forgo life-sustaining treatments for religious or other cultural reasons, demonstrates the ''understanding, humility, empathy, sympathy, sensitivity, tact, and . . . gentleness''[1] of the compassionate physician. Certainly, a compassionate physician will respect patients' spiritual needs and never trivialize their beliefs or cultures. In this way, demonstrating compassion shows patients that they are cared for and respected, thus cycling back to the development of trust.

CONCLUSIONS

The practice of EM challenges us daily. The challenges, however, are not only intellectual. To succeed, EPs need more than just a wide fund of medical knowledge; we require moral virtues as well. The virtues discussed in ''Virtue in Emergency Medicine'' are essential for achieving true excellence in EM. Although acquiring these virtues requires ongoing thought, reflection, and application, a close study of this superb essay can serve as a first step toward obtaining and perfecting these virtues for ourselves.

Ultimately, however, we must do more than simply acquire them for ourselves. As academic physicians, we must take the lead in spreading them to others. Larkin and Arnold[2] say that ''virtuous behavior can be modeled, mentored, practiced, and institutionalized to become one of our more useful vaccines against the threat of terrorism in the new millennium.'' As we have seen, however, virtue can vaccinate us not only against terrorism, but against all of the challenges and threats that face EM. The more we promote virtuous behavior among EPs, the stronger we can make our health care system and entire society.

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