VIRTUOUS MEDICAL PRACTICE

RESEARCH REPORT

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The University of Birmingham is a top ranking British University. Founded in 1900, it was England's first civic University and has been ranked University of the Year 2013–14 by The Times and The Sunday Times.

The original Department of Education was founded in 1894 and became the School of Education in 1947. Ranked in the top 50 Schools of Education in the world today, it has a long-standing reputation as a centre of excellence for teaching and research in a wide range of areas of educational practice and policy, with fields of expertise including disability, inclusion and special needs, education and social justice, and professional education.
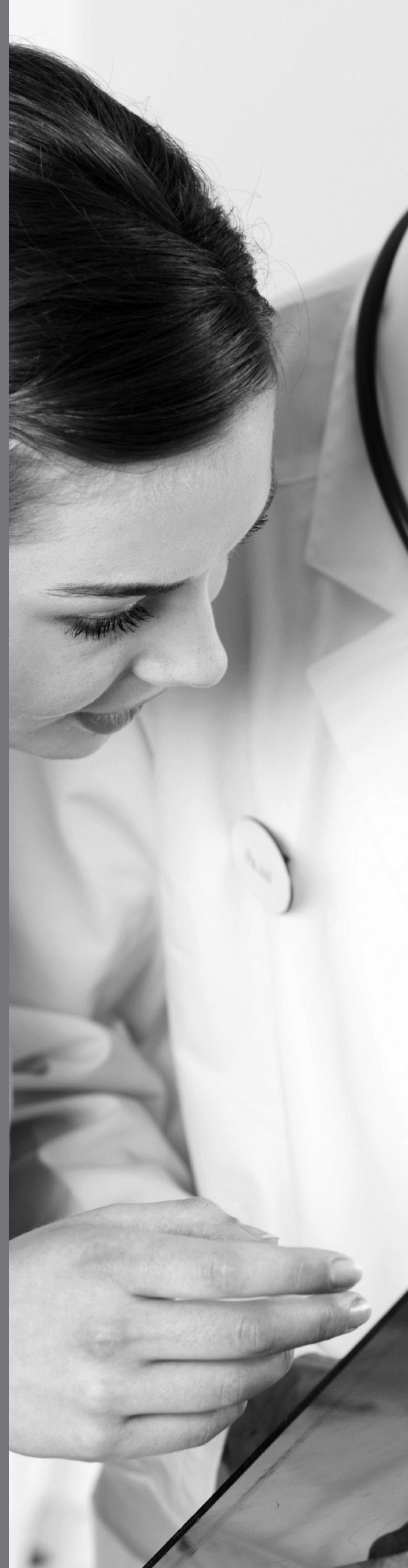
Jubilee Centre for Character and Virtues

The Jubilee Centre for Character and Virtues is a unique and leading centre for the examination of how character and virtues impact on individuals and society. The Centre was founded in 2012, by Professor James Arthur, with a multi-million pound grant from the John Templeton Foundation. Based at the University of Birmingham, it has a dedicated team of 30 academics from a range of disciplines, including: philosophy, psychology, education, theology and sociology.

With its focus on excellence, the Centre has a robust and rigorous research and evidence-based approach that is objective and non-political. It offers world-class research on the importance of developing good character and virtues, and the benefits they bring to individuals and society. In undertaking its own innovative research, the Centre also seeks to partner with leading academics from other universities around the world and to develop strong strategic partnerships.

A key conviction underlying the existence of the Centre is that the virtues that make up good character can be learnt and taught. The Centre believes that these have largely been neglected in schools and in the professions. It is also a key conviction that the more people exhibit good character and virtues, the healthier our society is. As such, the Centre undertakes development projects seeking to promote the practical applications of its research evidence.

This report was launched by Professor David Haslam, Chairman of the National Institute for Health and Care Excellence (NICE), on 14 January 2015, at the Royal College of General Practitioners in London.

Virtuous Medical Practice

Research Report

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We live in an era of rules and regulations. After 120 years of encouraging professional virtue by punishing egregious exceptions, the General Medical Council (GMC) in the past 30 years has moved into assessing performance, culminating in the periodic re-licensing of all doctors. After 40 years of an NHS (National Health Service) in which a doctor was 'expected to do what a doctor does', the use of contracts to define and control professional performance has become prevalent. For 15 years in England we have had both clinical guidelines through the National Institute for Health and Care Excellence, and increasingly pervasive service reviews by the Care Quality Commission. Monitor regulates much of the hospital sector.

Rules and regulations are one logical response to perceived problems of shortfalls or variations in care. Should we not be defining acceptable and good care and proactively seeking out examples where care is unacceptable? As a leading protagonist of revalidation, I am not about to argue for a return to *laisser-faire*.

However, there is a second response that is more powerful and effective. The core currency in medicine is the consultation (usually with the patient present, but sometimes not). Although there may be others in the room, these consultations are essentially private interactions between two experts – the one an expert on themselves and their choices; the other an expert on the science and art of medicine. The agreed decisions and plans for action will determine the outcome for the patient, an outcome that will be subtly or grossly different for each patient.

The skill that the clinician brings to that consultation is crucial. It requires knowledge and understanding of the options available; it demands high levels of communication; but it crucially depends on that doctor's values and virtues. These include the desire to help a patient find the best option for them; the desire to minimise risk of harm; the desire to balance, as far as possible, the wishes of individuals against the wider imperatives of societies; and a genuine caring compassion.

At an intuitive level, patients can assess the level of empathy and altruistic commitment of a doctor. They can assess the degree to which their views and preferences are valued and used in decision-making. More problematic is their assessment of the clinician's judgement and character. Colleagues often have good insight into these, and in the best teams, they support the development of both.

While rules and regulations can take snapshots of performance and attempt, often inadequately, to remedy defects, the best daily protection for patients comes from the values that each clinician carries within them. It is therefore essential that we recruit doctors and nurses with the right value systems, that we augment those values throughout training, that we encourage those values in established healthcare workers, and that we reward them through peer recognition.

So what does nirvana, in this context, look like? Firstly, each clinician would have a strong internal sense of appropriate and good behaviours, based on a robust set of inbuilt values and virtues. Second, the team in which that clinician works would expressly support virtuous behaviours, and offer support and guidance to colleagues who lapse. Thirdly, if things go wrong (as they invariably do) the subsequent exploration would be less about the mechanical aspects of 'who did what' and more about the ethics and values, the judgements and behaviours that contributed to the adverse outcome.

This research report from a special team in the University of Birmingham, looks at applied virtue ethics. Through interviews with health professionals in different stages of their careers, the researchers examined how values and virtues can be nurtured, and how our working environments can work against the exercising of our best intentions. The report arrives at sensible and implementable recommendations. If we are to regain trust in our health services, this report represents the foundations on which we must build.

Professor Mike Pringle
CBE PRCGP FRCPLon FRCPEdin FMedSci
President, Royal College of General Practitioners

Executive Summary

There is growing evidence in Britain to suggest that virtues such as honesty, self-control, fairness and respect, which contribute to good moral character, may be part of the solution to many of the challenges facing society today. Until recently, the language of virtue and the importance of virtue-based behaviour have been neglected in Britain.

The Jubilee Centre for Character and Virtues aims to help remedy this situation. As a world-leader in rigorous academic research into applied virtue ethics, the Centre operates on the basis that good moral character is possible and practicable, and that businesses can operate better when behaving virtuously.

The Jubilee Centre's new report, *Virtuous Medical Practice*, examines the place of character and values in the medical profession in Britain today. Its findings are drawn from a UK-focused multi-methods study of 549 doctors and aspiring doctors at three career stages, first and final year students and experienced doctors.

The report explores:
■ the motivations of those entering the medical profession;
■ the moral virtues that are prized within the medical profession;
■ the extent to which doctors' working environment enables or hinders the expression of moral virtue;
■ the nature of ethics education in medical schools; and
■ the potential contribution of ethical dilemma scenarios to initial and continuing medical education.

Key findings:
■ The Jubilee Centre's research finds that doctors and aspiring doctors at the three different career stages were in substantial agreement on the positive virtues that doctors are expected to adopt throughout their career. The top six character defining strengths are:
– Fairness
– Honesty
– Judgement
– Kindness
– Leadership
– Teamwork
Four of these strengths – fairness, honesty, kindness and teamwork – are also listed as self-reported character strengths but respondents are less likely to rank their qualities of judgement and leadership highly.
■ In explaining their thinking about ethical medical practice, experienced doctors were more likely to rely on their judgement, while those at earlier career stages were more likely to rely on rules.
■ Experienced doctors were positive about many aspects of their working environment, reporting a positive perspective on their emotional involvement with their work and on the autonomy that they are accorded. Support from colleagues is an important enabling factor for ethical practice.
■ Professional ethics is taught in medical schools but the emphasis is on rule-based and cognitive approaches. While the character of doctors is often recognised as important, it is not part of the formal curriculum.

■ Interviewees commented on the influence of role models in their initial education and subsequent practice. These role models and the wider culture of the workplace emphasise the importance of the 'hidden' curriculum in shaping a doctor's early professional identity and its later influence in the workplace.
■ Studies on means of assessing medical ethics are dominated by rule-based approaches. Virtue-based approaches must take a similar route if they are to secure greater influence. The results from the ethical dilemma scenarios used in this study show the approach could provide a way to examining doctors' moral character.

The report makes four main recommendations.
1) As experienced doctors rely more on character in resolving ethical dilemmas, compared with earlier career stages, 'literacy' in the language of character and virtue needs to be included in the formal curriculum of initial medical education and training. Embracing a variety of ethical theories will help students make sense of the moral nuances of being a good doctor.
2) Role modelling and workplace culture influence behaviour and character both in initial training and professional practice. As such, more attention should be given to informal training in moral character and senior staff should create more opportunities for reflecting on ethics in the workplace.
3) Virtues and rules can be mutually enriching and regulatory guidance would be strengthened by making these relationships clearer in regulatory documents.
4) Medical ethicists and educators should begin developing valid, reliable and fair means to assess doctors' moral character. Ethical dilemma scenarios provide a promising approach.

> 'IF A MAN HAS ANY GREATNESS IN HIM, IT COMES TO LIGHT, NOT IN ONE FLAMBOYANT HOUR, BUT IN THE LEDGER OF HIS DAILY WORK.'
>
> **Beryl Markham**

1 Purpose of the Report

Character and virtues remain central to the ethical enterprise of medicine. Identifying what character virtues are necessary for good medical practice, however, is fraught with difficulty. This research project investigated, over two years, the place of character and virtues, training and professional practice in medicine in the UK. The project aimed to identify which personal virtues medical students and experienced doctors hold and to investigate how these could influence their professional life, as compared to other values and factors. Specifically, it examined how an understanding of the virtues influences doctors' moral thinking and possible conduct, and how the environment in which doctors train and work can influence them in becoming good doctors.

This report is timely. Doctors' work – and the context in which they do it – is changing rapidly. Improvements in information technology and changes in social attitudes have both impacted on the doctor-patient relationship. Moreover, recent professional scandals have focused attention on doctors' moral character as never before. Despite this attention however, character in medicine has rarely been studied empirically. Even when the work of doctors has been explored through a moral lens, the focus has typically been on adherence to moral rules or codes rather than on the virtues that shape moral character. With this interdisciplinary project, we aimed to fill this gap in the literature. By researching the influence of character on medical education, training and practice in the UK, we aimed to provide the profession with baseline information on the basis of which educational interventions could be designed.

Our study included medical students in their first and final years at four UK medical schools, as well as practising doctors and medical educators across the UK. With students, we investigated how their education is informed by conceptions of the virtues, and how their initial medical education influences their character and values. With their educators, we explored how formal and informal curricula and assessment are informed and underpinned by concepts of professional virtues and values. With experienced practitioners, we examined the virtues they identify as being important to their profession and how these influence their everyday practice. Recognising that professionals work within institutional, regulatory and disciplinary frameworks, we also explored how these frameworks restrict or create space for individuals' character to flourish. By comparing responses across the three career stages, we built a picture of how conceptions of the virtues and their role change from entry, to graduation, to practice.

Key questions:
- Which virtues and values are held by members of the medical profession in the UK?
- How do doctors develop these virtues and values?
- How do virtues and values shape medical practice?
- How do these virtues and values relate to the expectations of the medical regulatory bodies?
- What are the implications of virtue-based medical ethics for ethics education in medicine?
- How can virtues and values be developed through doctors' initial training and continuing education?

This report presents findings and recommendations which we hope will provide a better understanding of how virtues and values inform, shape and enhance practice in the medical profession. We believe the report provides a resource for developing further character-based education in medicine.

['CHARACTER IS THAT WHICH REVEALS MORAL PURPOSE, EXPOSING THE CLASS OF THINGS A MAN CHOOSES AND AVOIDS.'

Aristotle]

2 Background

Medicine is a classical profession. One of the three original 'liberal professions' along with the priesthood and the law, nothing sets medicine apart from other spheres of work as much as the ethical relationship between the doctor and their patients. Doing justice to this relationship over a life-time of practice arguably demands not only adherence to a list of musts and must-nots. It requires curiosity and creativity, courage and honesty, teamwork and humour and a sense of fairness, a capacity to care for others, to show patience and forgiveness and to draw upon an inner resourcefulness. In short, being a doctor calls for qualities of good individual character.

Medical practice today takes place within specific regulatory, institutional, political and economic frameworks. This report begins by looking at some of the current challenges, as they play out in a UK context, and considers how these impact on the character a good doctor needs. It explains why a character-based approach to ethics in medicine is needed and what its most important features might be.

2.1 CHALLENGES IN CURRENT MEDICAL PRACTICE AND EDUCATION

The healthcare needs of the UK's population and the environments in which care is delivered are changing rapidly. Political devolution is leading to growing differences in the way healthcare is organised and delivered in the four countries of the UK, and ongoing reform, especially major structural change in England, has raised further uncertainty about the future shape of healthcare and its capacity to meet future demand.

Furthermore, the nature of doctors' work is evolving. Next to fast-paced technological change, doctors have to understand and find the balance between often conflicting factors when deciding the best course of action for their patients, which may have implications for the type of character virtues required by those in the profession. Greater emphasis on scrutiny, changes in the governance and organisation of the medical profession, as well as changes

in relationships of trust between doctor and patient, each have potential significance for the nature and balance of qualities required by doctors.

Medical education and training too are being provided in a changing environment. Curricular reforms have been introduced in UK medical schools to keep pace with these changes and the training and career paths of junior doctors have changed. While the European Working Time Directive strives to protect junior doctors and their patients from excessive time spent on-call, in absolute terms it cuts the time junior doctors have to learn their craft. The educational challenge is to adapt to a world of higher expectations and wider responsibilities where, more than ever, doctors will be expected to exercise good teamwork, understand the systems in which they work, and contribute to, and where appropriate, lead multidisciplinary teams. There is a real task in ensuring that future doctors with increasingly different backgrounds, skills, experiences and values are able to deliver consistently high standards of practice.

2.2 WHY DOES A DOCTOR'S CHARACTER MATTER?

Doctors are held in high esteem. Polls of public trust in the professions regularly find that doctors are the professionals most trusted by the British public; a recent Ipsos MORI poll found that 88%, nearly nine out of ten adults in the UK, trust doctors to tell the truth (Ipsos MORI, 2011). However, inappropriate behaviour by some doctors may be re-shaping public perceptions of the medical profession. This can be illustrated by exceptional but high profile cases of professional failures in the UK, such as the unacceptably high death-rate of babies undergoing heart surgery at the Bristol Royal Infirmary, and the organ retention scandal at Alder Hey Children's Hospital. The investigations into these scandals highlighted deficits not only in clinical competency, but in the ethical behaviour of some doctors and in monitoring by hospital authorities (Department of Health, 2001; Hall, 2001).

More recently, in the report on the Mid-Staffordshire scandal, chair of the enquiry Sir Robert Francis QC highlighted the higher than average mortality rate at the Trust and instances of very poor care at the hospital. In his report, Francis draws attention to a number of problems, including aspects of the culture of the Trust, standards and methods of compliance, poor communication and the effects of repeated reorganisation of the Trust. Francis's explanation of the Trust's failings is complex. It involves many systemic factors and does not put the blame on particular individuals. While systemic factors are of great importance[1], it is striking that much of what the report has to say calls into question the character of, if not identifiable individuals, then significant numbers of the nursing, medical and management staff of the hospital trust as a whole. Francis writes, for instance, that patients were treated with 'callous indifference' (Great Britain. Parliament. House of Commons, 2013: 13) and said in comments reported in the press that 'there was a lack of care, compassion, humanity and leadership' at the Trust (*The Independent*, 7 February 2013). While Francis does not sketch the entire problem as one of the character of the Trust's staff, his comments raise interesting questions concerning the relationship between the character of individuals, the culture of organisations and the quality of service that such organisations provide.

As Tallis (2006) noted, the errors and misdemeanours of the medical profession will always attract more media attention than the slow process of improving routine good practice. Concerned as we should be about medical misconduct, Tallis identified three further trends as to why the profession needs to examine itself today:

- Advances in technology have made medical information, once the exclusive province of the doctor, available to any member of the public who has a computer.
- The decline in deference has encouraged patients to challenge medical expertise.
- Intensifying consumerism has resulted in rising patient expectations (Tallis, 2006: 7).

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[1] We return to issues of context in section 4.3, below.

While technical knowledge and clinical competency are crucial attributes of a good doctor, advances in information searching and changes in diagnostic procedures have made information, once the province of the doctor, available to more people than ever before. The consequent challenge for doctors is to negotiate a shift from not only being an expert at diagnosis, but an expert at explanation, to be a sympathetic manager of expectations and a wise advisor as to what is practical. Rather than 'automating' part of a doctor's work, technology may in the end place different – and perhaps greater – demands on doctors' character.

Furthermore, the contemporary emphasis on shared decision-making between doctor and patient means that an 'old model' of medical professionalism, 'characterised by paternalism, emotional disengagement and establishing certainty', has been replaced by an emphasis on 'patient-centeredness and collaboration' (Borgstrom, Cohn and Barcley, 2010: 1330). Alongside trustworthiness, the virtues of empathy, openness, and respect for the patient are now also needed to exercise effectively this more equitable doctor-patient relationship (Borgstrom, Cohn and Barclay, 2010: 1331).

Lastly, patients' expectations are rising – patients want care that is not only good enough, but that is convenient and matches the level of customer care of other 'service providers'. The political context imposes demands of ever greater throughput of measurable services, often to the detriment of less tangible but equally important matters. The twin demands of economics and politics leave the NHS, in particular, to face particularly high levels of expectation from patients, politicians and the general public.

2.3 MEDICAL ETHICS AND PROFESSIONALISM: TOWARDS A CHARACTER BASED PERSPECTIVE

In the field of medical ethics, the concept of moral character or 'virtue' has experienced a revival. A virtue is a morally evaluable character trait of a person (such as honesty or courage). What distinguishes virtue ethics from other approaches to ethics is that it sees questions of morality as being primarily concerned with peoples' moral character (rather than with, for instance, how they reason about moral rules, or about the consequences of actions).[2]

What can be termed the 'virtue turn in medical ethics' can be traced to the work of authors such as Pellegrino and Thomasma (1993) who took inspiration from philosopher Elizabeth Anscombe (1958: 1–19) and others'[3] dissatisfaction with 'principle-based ethics' and offered, in its place, a conception of medical ethics that focuses on the virtues of the good, professional doctor. Traditional principle-based ethics sees the task of medical ethics as formulating rules or principles for good practice and proposes that practitioners will adhere to these principles if they are communicated and enforced clearly enough. However, the principles of medical ethics are abstract and need interpretation in context; furthermore an emphasis on compliance may encourage practitioners to satisfy the letter of the rule, rather than the spirit of excellent care it was designed to capture. By contrast, virtue-based accounts of medical ethics turn their attention away from features of the action being performed (whether, say, a treatment satisfies certain principles or criteria, for instance being beneficial, just, respecting autonomy, etc.) to the character of the practitioner making the decision or performing the treatment. There is growing support for a virtue-based approach to medical ethics (Coulehan, 2005; Bryan and Babelay, 2009; Toon, 2014) and, today, the field finds itself faced by a choice as to the purpose of education or regulation in the field of medical ethics: should medical ethics be concerned with the ability of medical practitioners to reason well in terms of principles, or should it be concerned that they be virtuous doctors? Eckles *et al.* (2005: 1145) call this the 'skill/virtue' dichotomy. The question is whether the essential purpose of medical ethics is to promote skills in reasoning and arguing about the principles of good medical

practice, or whether it should aim, instead, to influence the character of real doctors.

In medical ethics, the debate between advocates of rules-based and virtue-based approaches is voluminous. Advocates of rule-based approaches stress the advantages of systematising thinking about medical ethics by seeing all problems of medical ethics in terms of a small number of principles (such as the famous four principles of medical ethics of Beauchamp and Childress (1979) – beneficence, non-maleficence, justice and autonomy). Advocates of virtue approaches, on the other hand, stress the abstract nature of these principles and hold that, without a good deal of information about context, the four principles themselves do not provide a road-map to making ethical decisions in medicine. Space prohibits full discussion of the debate[4], however advocates of a virtue approach offer two main reasons as to why good medical practice is not a matter of knowledge or skills in reasoning with rules but is a matter of character.

2.3.1 Virtue Ethics Offers More Realistic Moral Guidance to Practitioners

One reason why advocates of a virtue approach reject 'principlism' in medical ethics is that principles are 'too abstract [and] that their use in moral judgments is too formularized and far removed from the concrete human particulars of moral choice' (Pellegrino and Thomasma, 1993: 19).

Rules or principles such as 'respect the patient's autonomy', 'do not harm the patient', 'act for the benefit of the patient', etc. are too general. Because rules do not affect people's actions all by themselves, but need to be interpreted in context, medical practitioners need to internalise a conception of what is right and good in order to be able to act on medical principles or rules.

A corollary complaint that is sometimes directed against virtue ethics itself is that it does not make available a step-by-step decision procedure on how to solve practical conflicts.

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[2] In this report, we use 'virtue' (in singular) and 'moral character' interchangeably; also 'virtues' (in plural) and 'character strengths'.

[3] For instance, Foot (1978) and MacIntyre (1984; 1990)

[4] A substantial literature exists on whether principles or virtues should drive medical ethics; for a good introduction see the papers collected in Savulescu (2003). A third possibility is that medical ethics should firstly be concerned with the consequences or utility of particular medical decisions; see Singer (1993). For a general introduction see Hope *et al.*, (2008).

However, expecting such a decision procedure may be unrealistic in medical diagnosis and treatment that is often based on expertise at identifying patterns rather than calculation (Schmidt *et al*., 1990). Rather than decision-rules for action, virtue approaches to medical ethics seek to provide an account of good judgement in medicine. According to Kaldjian (2010) there are strong similarities between wise ethical judgement in medicine and what we would ordinarily call 'clinical judgement'. Both of these, Kaldjian holds 'requires repetitive and supervised practice over years of training so that trainees can learn a skill that comes by experience…' (Kaldjian, 2010: 560 – 1). Advocates hold that virtue theory is better equipped than principles-based thinking to make sense of the complex weighing up of goals, goods and options that characterise real clinical judgement, because of a focus on wisdom and good judgement (*phronesis*).

2.3.2 Virtue Ethics and Excellence

Larkin *et al*. speak for many when they hold that 'modern medicine has become steeped in the tradition of rules, laws, scientific principles, and utilitarian practice guidelines' (Larkin *et al*., 2009: 52). A second complaint that is often voiced against the effort to codify what counts as good medical practice in terms of outcomes, targets or compliance with procedures, is that such codes set a *minimum* standard for what is to count as good practice and encourages an attitude of *compliance* with such standards. As long as the practitioner complies with these minimum standards, that is 'good enough'.

According to Barilan and Brusa (2012: 5), virtue ethics offers the antidote to this view in that it is 'excellence-oriented'. Virtue theorists in medicine place much emphasis on the overall aim[5] of medicine, which is achieving the 'patient's good'. In order to achieve this – demanding – good for the patient, the physician cannot only rely on satisfying principles or abiding by rules. Instead, the physician must demonstrate those virtues in their medical practice that are the only route to the attainment of that demanding aim; virtues such as fairness, honesty, judgement, kindness and others (see section 4.1). However, we need to be aware of Veatch's caution when he argues that:

> There is a more basic problem with the argument that the reason we value good character is that it will increase the probability of right behavior. Such an argument values character instrumentally. Someone who advocates the teaching of virtues in medical education because it will promote wise discernment of what behavior is morally required is actually acknowledging that it is really conduct, not virtue, that is the moral bottom line. (Veatch, 2006: 34)

According to virtue approaches to medical ethics character in medicine is important in itself and is more than a means to secure right conduct.

2.4 MEASURING CHARACTER IN MEDICINE

Taking a virtue perspective on medical ethics brings one to confront the question of how character or virtue in medicine can be studied empirically. At first glance, the idea that one may measure the character of a doctor empirically seems strange. Talk of measuring doctors' moral character may also seem politically objectionable. What business is it of professional and regulatory bodies what a doctor's moral character is like? Moreover, who is to determine what constitutes acceptable moral character for a doctor and whether a particular doctor meets this character test or not?

However, if right action in medicine is determined, partly or even essentially, by the *character* of the doctor who performs the action, it will be necessary to *be able to tell* whether a doctor is virtuous in order to determine whether they practice medicine morally or not.

Being able to tell whether a doctor practices medicine in a morally virtuous way will be especially important in the fields of medical education and medical regulation.

Firstly, without being able to understand professionals' character as it is, it will be hard to know what it is about medical students' and young doctors' character that needs to be shaped through appropriate moral and character education in the medical field.

Secondly, without being able to assess how a student or doctor's character changes or has changed, it will be impossible to know whether any educational intervention designed to shape doctors' character has been effective.

Thirdly, without being able to assess practising doctors' character, it will be impossible to identify the minority of doctors who deserve either remediation or sanction in terms of their moral character.

If they are to make an impact in fields like the education and regulation of doctors, then, virtue-based approaches to medical ethics cannot ignore the matter of assessment of doctors' moral character. In other words, if virtue-based approaches are to match the impact that rules-based approaches already have, they must begin the (complicated) process of developing valid, reliable and fair means to assess doctors' moral character.

In medical education today, there is broad agreement that 'education is about more than acquiring an appropriate level of knowledge and developing relevant skills', and that, 'medicine students need to develop a professional identity' (Goldie, 2012: 641). Whilst such sentiments are widely acknowledged in the theoretical and educational literature on medical ethics, empirical resources to study doctors' *character development* (as distinct from their ability at moral reasoning) are scant. Other authors have reported that it is not always clear how professional ethics in medicine should be taught, and how it should be assessed is a matter that is even less clear (Calman and Downey, 1987; Cowley, 2005; Mattick and Bligh, 2006). Presently, no agreed method to understand the moral character of professionals exists, meaning that medical ethicists, educators and regulators who adopt a virtue ethics perspective may perhaps be seen as mostly flying blind in their efforts to shape the character of the medical students and doctors under their charge.

Medical education is not simply about conveying knowledge; it is also concerned with transformation in nurturing the character of the good doctor. However, as Veatch, a critic of a virtue ethics approach to medicine, notes 'there is not only a problem of whether instilling virtue leads to the correlated behaviour. There is [also] the much more serious problem of identifying which character traits would be good to instill' (Veatch, 2006: 44). One of the aims of this project was to address this concern.

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[5] For Aristotle, the 'telos'.

2.4.1 Assessment Tools for Measuring Ethics and Professionalism in Medicine

In order to understand empirical approaches to medical ethics, we undertook a literature review to establish what are the most frequently used psychometric measures of professional ethics in medicine. We searched MEDLINE and PUBMED using combinations of the following keywords: 'assessment', 'measurement', 'ethics', 'professionalism' and 'virtue'[6]. Twenty four publications were retrieved from the literature and we used the reference lists of these to identify a further 47 studies. We also identified four previous reviews of assessment tools for measuring ethics and professionalism in medicine, with the most recent being from 2006 (Self and Baldwin, 1994; Bebeau, 2002; Baldwin and Self, 2005; Bebeau, 2006). As these four articles reviewed the empirical study of doctors' ethics exhaustively, the analysis for this research focused on studies since 2006.

We categorised all studies according to their theoretical approach and found that – both before 2006 and since – most studies are principles-based in their orientation. By contrast, we could find only one empirical study from a virtue-perspective (Schulz et al., 2013) even though ample theoretical discussion of medical ethics from a virtue-perspective exists[7].

Self and Baldwin (1994), Baldwin and Self (2005) and Bebeau (2002, 2006) surveyed the literature on ethics assessments in medical education[8] and concluded that measures of general moral reasoning are the most influential in shaping thinking about how to assess doctors' ethics empirically. The instrument most often used is the Defining Issues Test ((DIT) Rest, 1979). Two features of the DIT that stand out are that:

1) it tests for ability at moral reasoning – the DIT tests for how well a respondent can reason, justify or, in general, 'talk about' what is the right thing to do in a certain situation; and

2) it is general – the moral dilemmas that the DIT sets participants are general moral problems that people may face in everyday life and are not specific to a profession or situation.

These two factors mean that tests such as the DIT are not in themselves designed to understand medical students' or doctors' moral and character development as *practising*

doctors. Firstly, while they may test for moral thinking, there is no guarantee that those who think well about moral situations will also do what is right. Secondly, in posing general moral dilemmas, tests such as these do not contain medical context, nuance and detail.

Some profession-specific measures of moral reasoning (containing dilemmas only relevant to one profession) do exist. The best example is the 'Dental Ethical Reasoning and Judgement Test' (DERJT) very widely used in Dental Education (especially in the USA). Given the success of the DERJT in the field of dentistry, there have been attempts to design a similar measure for medicine – Caldicott, Faber-Langendoen, Bebeau, and Thoma (2010) report on the development of the Medical Ethical Reasoning and Judgment Test (MERJT); the Medical Intermediate Concept Measure of Ethical Reasoning (MD-ICM) is another measure for medicine (Pinijphon, 2009). However, neither of these two tests has been comprehensively validated and the impact of them on medical selection and assessment to date has been small.

Most work on studying moral development in medicine, then, has been:

■ focused on moral reasoning only; and

■ quite general (or non-profession specific), with no agreed, profession-specific measure of moral development being available.

Responding to these two pressures, we decided to investigate the prospects for developing virtue-based studies of moral development in medicine. Developing such an approach would have the twin advantage of being more encompassing than focusing only on moral reasoning and of being profession-specific (due to the importance that virtue ethics places on context, any virtue 'measure' would also have to be a highly context-specific one).

2.4.2 What Would a Virtue Approach to Moral Dilemmas Look Like?

For Aristotle, the founder of traditional virtue ethics, a virtue is a trait of a person's character (*hexis*); it is (once developed) a stable trait that influences the way a person acts from a moral point of view. Aristotle held that each character trait of this sort consists of a different set of developed tendencies that a person has to do the following things:

■ to recognise or perceive moral situations correctly (to be sensitive to what is at stake in a situation);

■ to respond emotionally to that situation in the right way (this may include being dispassionate in the right circumstances);

■ to think well about what to do in the situation (either to know how to act or to reason appropriately about how to act); and

■ to be motivated strongly enough to carry the right action through.[9]

All of these processes of sensitivity, emotion, reasoning and motivation need to be coordinated in action with a certain manner or style, and virtuous action consists in all of these elements operating in harmony in a specific situation. What we tried to achieve with our study was to design moral dilemmas that would tap all four of these processes in an intuitive way.

Importantly, our study was not aimed at designing a validated psychometric *test of* or *measure for* virtue. Rather, the study used approaches from existing psychometric tests to survey how doctors justify, reason about, or understand moral practice in their profession. Noting that virtue theory is becoming increasingly more important in medical ethics, we thus set out to conduct an exploratory study of medical students' and doctors' moral development from a virtue-based perspective. As an initial study of how character influences medical students and doctors, it provides a basis from which other studies can develop approaches to understanding and assessing how character develops through medical education and practice. As far as we could ascertain, this study is the first empirical study of its kind.

> '[NO ONE HAS THE IDEAL SET OF CHARACTERISTICS TO BE THE BEST DOCTOR.]'
>
> **Anonymous**

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[6] Criteria used to include a measure/assessment/test were: (1) pertains to medical education and/or some aspect of professionalism in medicine, and (2) empirical evidence of its use.

[7] The problem is not confined to medical ethics, but is one that affects the empirical study of ethics and moral development generally. See Curren and Kotzee (2014).

[8] …and professional education more broadly, in the case of the papers by Bebeau (2002, 2006).

[9] See Curren and Kotzee (2014), Fowers (2014) and Kristjánsson (2015) for discussion of the psychology of virtue.

3 **Methodology**

In this section, we report on the research methods employed in conducting this study.

3.1 RATIONALE

The project comprised a mixed-methods, cross-sectional study of the role of character in ethical medical practice. The cross-sectional design enabled us to compare cohorts at three career stages: medical degree entrants, graduating students about to embark on hospital practice and experienced professionals (defined as doctors with at least five years of experience of medical practice).

The survey was designed to study virtue in medical practice from three different perspectives:

■ What do medical students and doctors say about character in medicine?
■ How do considerations to do with character influence medical students' and doctors' thinking about *real moral dilemmas* in medicine?
■ What are the *contextual factors* that may shape and influence medical students' and doctors' character?

Recognising that quantitative data, even when collected from sizeable populations such as these, cannot fully do justice to the nuances of professional practice that is complex, the research team also undertook *semi-structured interviews* with a sample of participants. The interviews provided a better understanding of the conditions under which virtue can be enacted and how better to create circumstances conducive to virtue, both within the workplace and without. They also offered an opportunity to focus on pertinent questions, test out quantitative analyses of datasets, and deepen the understanding of practical knowledge suggested in the survey.

3.2 RESEARCH DESIGN AND INSTRUMENTS

The project began with a scoping period, involving a review of literature and discussions with a range of experts representing organisations involved in ethics regulation or governance. Following this, various instruments were designed and are discussed in more detail below.

3.2.1 The Survey

The survey[10] consisted of five sections (four for starting undergraduates), surveying:

1) **Respondents' views on their own character.**
   This comprised a list of 24 character strengths, derived from the *Values in Action Inventory of Strengths* (VIA-IS) (Peterson and Seligman, 2004) from which respondents were asked to identify the six which 'best describe the sort of person you are'.
2) **Respondents' responses to a set of moral dilemmas in their profession.**
   This comprised six situational judgement tests (Patterson and Ashworth, 2011; Lievens and Patterson, 2009) designed by a panel of experts (n = 15)[11] in medical education who adapted well-known dilemmas from the literature and designed a wholly new set of answer responses specifically for this study[12].
3) **Respondents' views on the character of the 'ideal' professional in their profession.**
   This comprised the list of the 24 VIA-IS character strengths presented again, with participants being asked to 'choose the six which you think best describe a good doctor'.
4) **Respondents' views regarding their work or study environment.**
   This section adapted questions from a Europe-wide workplace survey (Eurofound, 2012) with additional questions on ethical issues in the workplace.
5) **A set of demographic questions.**

3.2.2 Semi-structured Interviews

The research team devised a themed set of questions for interviews[13] with participants in the three career stages, based around the main research questions. These included questions around:

■ reasons for choice of career,
■ characteristics of a good professional (ie, doctor),
■ factors that can help – or hinder – being that kind of professional,
■ views on the influence of character on everyday professional practice,
■ the influence of the professions' code of conduct/standards; and
■ the influence of education and training in developing the strengths necessary for good professional practice.

For interviews with educators, a separate set of questions was devised which concentrated on:

■ their role in educating future doctors,
■ their view of a good professional in their field,
■ how this has changed in the course of their career,
■ how students are assessed for entry,
■ whether the character strengths required change and why,
■ what informs their teaching in relation to the virtues; and
■ how their stage of education can be developed.

3.3 PARTICIPANTS

In order to ensure good geographical representation, data were gathered from participants at four sites. These sites clustered around medical schools in the south of England, the midlands, the north of England and Scotland. First year students were surveyed on entry and final year students were surveyed shortly before graduation. Interviews were also conducted with educators at these four medical schools. Practising doctors in the four regions were recruited principally with the assistance of the Royal College of General Practitioners and the Royal College of Physicians, who agreed to email links to the survey to members in those regions.

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[10] A copy of the online survey can be found at www.jubileecentre.ac.uk/professions
[11] For membership of the expert panel, see Appendix 2.
[12] For more on the design of the situational judgement tests, see www.jubileecentre.ac.uk/professions
[13] A copy of the interview schedule can be found at www.jubileecentre.ac.uk/professions

The total number of interview and survey respondents, by career stage and gender, are presented in the tables below.

As shown in Chart 1, amongst practising doctors, general practitioners were the largest group in the survey sample (GMC approved single specialities, 2011).

Interview participants were chosen purposively from survey participants. An invitation to interview was based on the completion of a *willingness to be interviewed* section on the survey.

3.4 DATA ANALYSIS

3.4.1 The Survey
Data were collected using an e-survey. Data were transferred to SPSS version 21, checked, cleaned and readied for analyses. Analyses included descriptive analysis, cross-tabulation, correlation and factor analysis. Analyses were also developed to deal specifically with the results of sections 1 and 3 (respondents' views on character) and section 2 (moral dilemmas).

3.4.2 Semi-structured Interviews
Analysis of interview data was thematic, using a constant comparison (Glaser and Strauss, 1967) within a modified framework approach

(Richie and Spencer, 1994). The team members independently analysed the data from the interviews and developed the codes. Codes were created both horizontally and vertically and then developed into categories and themes. Categories were refined and coding reviewed throughout the process for which the NVIVO software was used.

3.5 LIMITATIONS OF THE STUDY

A number of limitations pertaining to the study deserve to be borne in mind.

The study was cross-sectional. Whilst a longitudinal design would have been ideal to chart the *development* of character through medical education and practice, the time that it would take to track medical students from university entry to experienced practice excluded the possibility of such a design. Due to possible variation in the membership of the three cohorts studied, questions may be raised about exact comparability between the groups.

A further limitation that affects all three study cohorts is response bias[14]. Participation in the study was voluntary and full participation by all who were invited to respond could not be ensured. That meant that only those participants who were disposed favourably enough to the topic (whatever their views on it) responded. Consequently, the survey and interviews represented the views of a self-selected group of people and not a perfectly unbiased sample.

A further limitation affects the cohort of experienced professionals with the preponderance contacted with the assistance of the Royal College of General Practitioners and Royal College of Physicians skewing the profile of respondents.

3.6 ETHICAL CONSIDERATIONS

The study received ethical approval from the University of Birmingham Ethics Committee. Full information regarding the study was set out in an information leaflet. As the study covered potentially sensitive topics, such as ethical dilemmas that students and doctors may have faced, all participants were asked to opt in to participation in the study. Participants' confidentiality was protected by anonymising survey responses and interview transcripts and participants were given the right to withdraw from the study up to six months after the data collection phase ended.
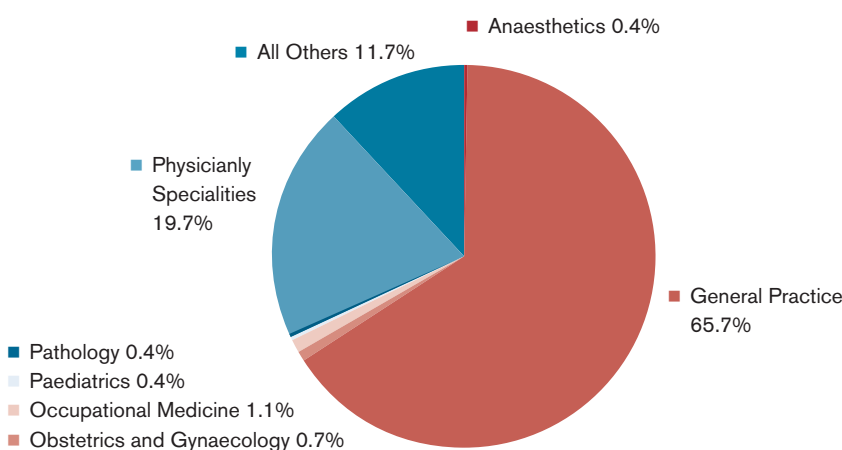
Table 1: Total Number of Respondents by Career Stage

Career stage	Number of surveys completed	Number of interviews conducted
Undergraduate students	122	23
Graduate students	152	24
Established doctors	275	28
Educators	n/a	10

Table 2: Total Number of Survey Respondents by Career Stage and Gender

			Career stage		
			Undergraduate students	Graduate students	Experienced doctors
Gender	**Female**	%	60.7	67.1	51.6
	Male	%	39.3	32.9	48.4

Chart 1: Experienced Doctors by Speciality

- Anaesthetics 0.4%
- All Others 11.7%
- Physicianly Specialities 19.7%
- General Practice 65.7%
- Pathology 0.4%
- Paediatrics 0.4%
- Occupational Medicine 1.1%
- Obstetrics and Gynaecology 0.7%

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[14] More generally, surveys of character (like personality testing more generally) suffer from self-report and social desirability biases.

4 **Findings and Discussion**

In this section, we present findings relating to the following four questions:

- What do we know about the character of medical students and doctors from what they say about themselves?
- What do we know about the character of the good doctor from what medical students and doctors say about good doctors?
- What role does character play in medical students' and doctors' responses to ethical dilemmas in medicine?
- How is character influenced by the contexts in which a doctor works?

4.1 PERSONAL AND PROFESSIONAL VIRTUES

4.1.1 Personal Virtues

Section 1 of the survey asked respondents to consider their own character. Respondents were provided with a list of 24 character strengths (from Peterson and Seligman's Character Strengths and Virtues Classification, 2004) and asked to rank the six they thought best reflect their personal character.

As a group, doctors and medical students exhibited strong agreement regarding the character strengths they reported they possess. Five strengths out of the 24 were selected by members of all three cohorts as best reflecting their character: fairness, honesty, kindness, perseverance and teamwork. Only one small difference emerged between cohorts as to the strengths they feel they hold: graduating students reported that they possess the strength of humour to a greater degree than first-year undergraduates (p<0.05). We found however a number of gender differences as to what respondents reported about their own character: women were more likely to report kindness as a personal strength than men, while men were more likely to report humour as a personal strength (p<0.05).

Amongst the least reported character strengths were bravery, prudence and zest. Table 3 shows the percentage of choices for each character strength, with the strengths selected most frequently in red and those least selected in blue[15].

The interviews also yielded information about the virtues medical students and doctors perceive in themselves. When asked what character strengths they hoped to demonstrate as a doctor, the most important for respondents were: being caring, being trustworthy and having a good relationship with patients.

Well I hoped to be the kind of doctor that the local people would trust and feel it was easy to talk to. (Undergraduate student)

I think I wanted to be a caring one and someone who was with their patients rather than separate from them, if that makes sense. And I think someone who talked – you know, who talked and listened would always have been high on my list. (Experienced doctor)

Interestingly, the experienced doctors reported that whilst their formal education prepared them to be knowledgeable and competent in medicine, the 'softer' qualities of being a doctor were learnt through experiences in the workplace:

Table 3: Respondents' Reported Personal Character Strengths

Figures in %	Undergraduate students	Graduate students	Experienced doctors
Appreciation of beauty	1	2	2
Bravery	1	1	1
Creativity	3	3	2
Curiosity	7	5	5
Fairness	8	8	10
Forgiveness	3	2	2
Gratitude	3	3	2
Honesty	9	9	11
Hope	2	1	2
Humour	5	8	7
Judgement	4	3	4
Kindness	9	10	8
Leadership	5	4	5
Love	2	3	2
Love of learning	6	6	5
Modesty	4	3	3
Perseverance	8	7	6
Perspective	3	4	4
Prudence	1	1	1
Self-regulation	3	2	3
Social intelligence	2	5	4
Spirituality	2	1	3
Teamwork	6	7	7
Zest	1	1	1
	100%	100%	100%

[15] With 24 items to choose from, the top six do not account for all choices and one item from a set of six can only amount to a maximum of 16.7% of all choices. Thus, if 'honesty' represents 11% of all choices by experienced doctors (see Table 1), it means 66% of experienced doctors selected that item as one of their top six personal strengths.

I think when you're a junior doctor, it's so sort of task orientated, what you're doing, you're running from one task to another, I don't think I, through much of my early years as a junior doctor, I thought a great deal about that. I think when I became a registrar (…) I spent more time talking to patients, partly 'cause I did more clinics, so you spend more time seeing patients, you get to know patients a little bit better and it's more common that you have to explain, give bad news to patients, speak to relatives, so you then start to appreciate some of the importance of empathy and valuing patients' beliefs, etc.. (Experienced doctor)

I guess it was something that sort of rubbed on you and you developed it by thinking carefully around what you saw. (Experienced doctor)

This was also echoed by graduates who commented that they learned professional behaviour through exposure to more senior professionals and informal peer reflection. Undergraduate students too considered education on the theme of professionalism to have more value later in their training years:

I think life experience, if anything, is what will put me in good stead of being a good, when I say doctor I mean a good personable person. I think the course will help with the medical knowledge obviously but no, in terms of being a good doctor, in terms of the art of being a doctor, I think that's just life experience. (Undergraduate student)

4.1.2 Professional Virtues
In section 3 of the survey, respondents were presented with the same 24 character strengths as in section 1, but this time they were asked to rate the top six needed by the 'ideal' doctor.

While there was a good level of agreement between all three cohorts as to their personal character strengths, there was even greater agreement amongst them regarding the virtues they expect in the 'ideal' doctor. All three cohorts placed the same character strengths in their top six: fairness, honesty, judgement, kindness, leadership and teamwork. Some gender differences emerged as to what respondents reported about the character of the 'ideal' doctor. In particular, women were more likely to report judgement, kindness and leadership as strengths needed by the 'ideal'

doctor than men. Table 4 shows the distribution of choices for each character strength, with the most selected items shown in red and least selected shown in blue.

The degree of agreement amongst respondents about these qualities is striking, as it is notably higher than the same analysis of students and professionals in related studies in the professions of law and teaching (Arthur et al., 2014; Arthur et al., 2015). Table 5 shows that across the three career stages, the same six virtues – the same 'common strengths' – were selected as characterising a good doctor. Moreover, these six represent the choices of 62% of first year students, 66% of graduates and 61% of experienced professionals in medicine, as compared to a range of 40% to 44% for students and practitioners of law and 50% to 54% for student teachers and teachers. Evidently then, doctors show a higher level of agreement on the character strengths important for a good doctor to possess than

students and members of the other two professions (see Table 5).

A comparison of results from sections 1 and 3 of the survey shows that doctors and would-be doctors have a consistent view about the character of the 'ideal' doctor. As a group, the medical students and doctors who responded to the survey held that the 'ideal' doctor is fair, honest, kind, a leader, a good team player and a person with good judgement. By and large, the respondents as a group also held themselves to possess several of these strengths, presenting themselves as fair, honest, kind and good team players. There is, therefore, a substantial overlap between what character strengths or virtues the respondents think they should exhibit as professionals and how they think they are themselves. Yet, given this level of agreement, the differences concerning the strengths of leadership and judgement between the top personal and professional virtues are notable. Respondents

Table 4: Character Strengths of the 'Ideal' Doctor

Figures in %	Undergraduate students	Graduate students	Experienced doctors
Appreciation of beauty	0	0	0
Bravery	1	1	1
Creativity	1	0	0
Curiosity	5	3	4
Fairness	7	7	9
Forgiveness	0	0	0
Gratitude	0	0	0
Honesty	12	15	14
Hope	1	1	1
Humour	1	1	3
Judgement	10	9	10
Kindness	10	11	10
Leadership	9	10	7
Love	1	1	0
Love of learning	6	6	7
Modesty	2	1	1
Perseverance	7	7	4
Perspective	4	5	4
Prudence	2	1	1
Self-regulation	3	3	6
Social intelligence	5	5	4
Spirituality	0	0	1
Teamwork	14	14	11
Zest	0	0	0
	100%	100%	100%

to the survey were more likely to report that leadership and judgement are strengths that the 'ideal' doctor should possess than they were to report those as strengths they possess themselves (p<0.05).

Compared with the clarity of the survey data, the interviews provide a slightly more nuanced picture. One theme that emerged strongly is that character in medicine is not a matter that is finished or settled, but is a matter of development. Experienced doctors, especially, pointed out that all doctors should strive to embody good character strengths, but no one is ever the 'finished product':

No, no one has the ideal set of characteristics to be the best doctor. (Experienced doctor)

I think that is the thing, being a doctor you are never a finished product. (Experienced doctor)

Two themes emerged on influences on a doctor's character: what one's character was like innately or naturally and how experience shapes character. One respondent, for instance, could not settle which was more important:

I think a huge part of [good character] is innate. Some people are…I don't know, but certainly some of it is innate. You know, and I remember, you know, right as house officer, sort of within the first few weeks, you know, sitting up with the patient when I could have gone back to bed. Just sort of sitting and talking to her (…). But I think you get better at, certainly, things like – I'm in geriatric medicine now, so we do a lot of breaking bad news and sort of dealing with patients with dementia that sort of – dealing with families of people that are going to die and things like that. So that, certainly, is an evolving skill. (Experienced doctor)

Doctors spoke extensively about the influence of colleagues and role models on the development of good character in a doctor, and in section 4.3 of the report we return to this important issue.

4.2 VIRTUES AND MORAL DILEMMAS IN MEDICINE

We have seen that the virtues identified by respondents as most important to good medical practice are: fairness, honesty, judgement, kindness, leadership and teamwork. How do these virtues influence doctors and medical students' moral decision-making in practice?

To examine this issue, we designed 'six situational judgement' tests (Patterson and Ashworth, 2011; Lievens and Patterson, 2011) to study the role of character in moral dilemma situations in medicine. The situational judgement tests, we hoped, would give us an insight into: (a) which character strengths are important in dilemma situations in medicine; (b) how; and (c) how they interact with other factors, such as explicit rules for medical practice and the consequences of certain decisions[16].

In what follows, we illustrate how these virtues may operate, sometimes together and sometimes in conflict, in three example dilemma situations[17]. These three examples were chosen because they best illustrate how the virtues of the 'ideal' doctor identified by respondents operate in concert, and how reasons to do with virtues and, in some notable cases, rules for conduct, influence medical students' and doctors' moral decision-making.

Table 5: The 'Ideal' Professional: Three Professions' Views Compared

	Medicine	Law	Teaching
Number of common strengths identified (n)	6	5	5
Percentage of starting students identifying those common strengths as 'ideal' (%)	62	43	54
Percentage of graduating students identifying those common strengths as 'ideal' (%)	66	40	53
Percentage of experienced professionals identifying those common strengths as 'ideal' (%)	61	44	50

[16] For more regarding the design of the situational judgement tests, see www.jubileecentre.ac.uk/professions

[17] Discussion of all six dilemmas can be found at www.jubileecentre.ac.uk/professions

DILEMMA 5:
A CONFLICT BETWEEN KINDNESS AND LEADERSHIP[18]

In dilemma 5, respondents were presented with the following dilemma and options:

You are a junior doctor on call at a local hospital. A colleague arrives at the hospital to take over from you, smelling of alcohol. This is not the first time this colleague has arrived at work smelling of alcohol.

What would you do?

OPTIONS:

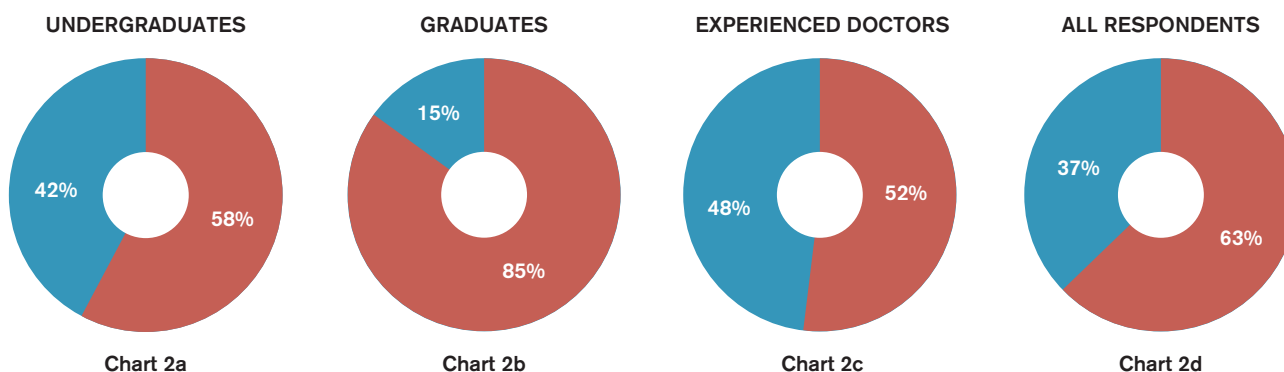1. Speak to your colleague privately
2. Speak to the supervising consultant

REASONS:

OPTION 1	OPTION 2
You chose to speak to your colleague privately. Please rank the three answers that best match the reasons for your decision	**You chose to speak to the supervising consultant. Please rank the three answers that best match the reasons for your decision**
1 You want to maintain a friendly professional relationship with your colleague	You want to avoid potentially harmful consequences for patient safety
2 You are concerned about your colleague and want to help him/her	There may be risks for you personally if you do not report him/her
3 You want to give him/her a chance to explain and improve	It is not your responsibility to deal directly with your colleague
4 You want to try and resolve the issue without getting formally involved	NHS policy encourages whistleblowing – you would be following guidance
5 You are following General Medical Council guidance	No harm will be done to your professional relationship with your colleague, as you will report him/her confidentially
6 You are trying to solve the problem without damaging the career of your colleague	You will protect your colleague's reputation

In responding to the dilemma, 63% of respondents reported that they would speak to their colleague privately, and 37% that they would speak to the supervising consultant. However, there were notable differences between cohorts as to how likely they would be to speak to a supervising consultant about the matter. Amongst graduating students, only 15% indicated that they would speak to the supervising consultant, compared with 48% of experienced practitioners and 42% of first year undergraduates. Compared with students[19], experienced professionals were more likely to speak to the supervising consultant in response to the matter ($p < 0.05$). Chart 2 (a–d) shows the results for all groups.

RESPONSES:

UNDERGRADUATES	GRADUATES	EXPERIENCED DOCTORS	ALL RESPONDENTS
42% / 58%	15% / 85%	48% / 52%	37% / 63%
Chart 2a	Chart 2b	Chart 2c	Chart 2d

[18] Dilemmas are presented in a thematic order, rather than in the order they appeared on the survey.

[19] That is, with the undergraduate and graduate students together.
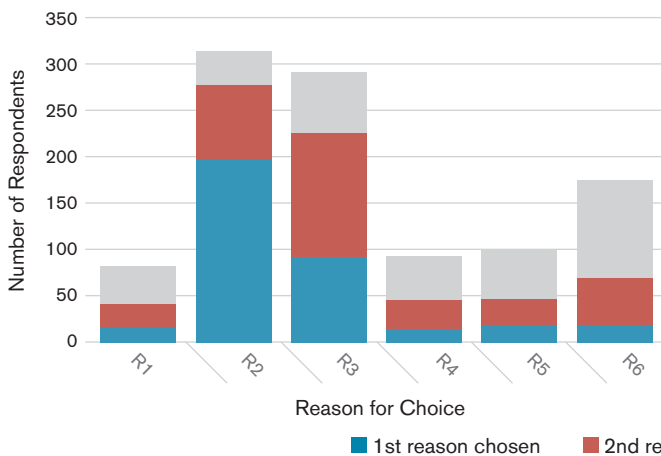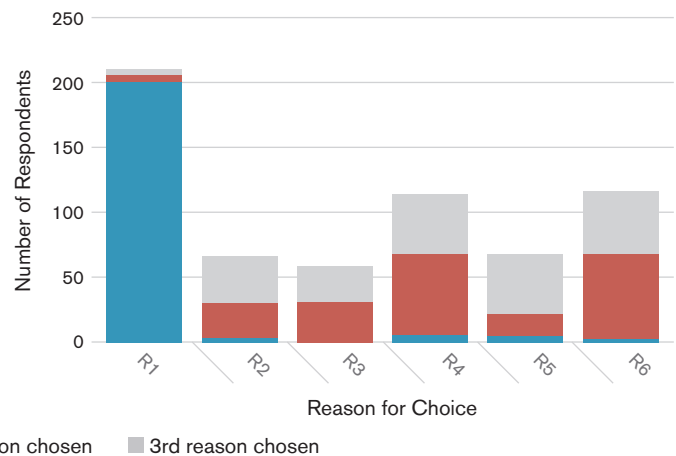
Chart 3: Dilemma 5 Option 1 – All Respondents

Chart 4: Dilemma 5 Option 2 – All Respondents

■ 1st reason chosen   ■ 2nd reason chosen   ■ 3rd reason chosen

The most striking response was that 85% of graduating students would deal with the matter privately (compared with 58% of first year students and 52% of experienced doctors). This result was followed up qualitatively through discussions with medical educators and it was found that the largest group of graduating students in our sample had only recently received teaching in ethics and professional conduct, where the guidance had been that attempting to deal with the matter privately first and refraining from formal action or complaint in the first instance, was the most professional manner in which to handle a situation like this. While this may explain the reason why graduating students preferred this course of action, the reasons that they gave for selecting this course of action are also revealing.

Why did respondents pick option 1? In selecting from the six reasons available for option 1, dealing with the matter privately, reason 2, 'You are concerned about your colleague and want to help him/her' was most frequently selected and also as the first reason chosen. The expert panel who designed the dilemmas were of the opinion that this reason, if chosen, would point to the virtue of kindness amongst respondents. Reason 3 'You want to give him/her a chance to explain and improve' was next most important. The expert panel were of the opinion that this reason, if chosen, would point to the virtue of fairness or perspective. In third place was reason 6, 'You are trying to solve the problem without damaging the career of your colleague', which the panel also took to illustrate a respondent drawing upon the virtue of kindness. The least selected reasons 1, 4 and 5 (in that order) according to the panel, reflected the virtue of wanting to work as a team with the colleague, a concern with mere consequences and a concern to follow GMC guidance. Chart 3 shows the results for all three career groups in choosing option 1 for dilemma 5.

Especially noteworthy in this dilemma is that the graduating students – whom we learnt had been taught that attempting to deal with this matter privately in the first instance was the most professional course of conduct – gave broadly the same reasons for their choice as the other respondents in the sample. It is of course impossible to be certain of their motives in responding this way. It seems, however, that while many of the group of graduating students had been taught something in particular about a dilemma like this, the reason they offered to justify this course of action was still the same as that offered by the other respondents. Put differently, the graduating students as a group did not offer a mere rule or convention as the reason why they would choose to speak to their colleague privately in the first instance.

Why did respondents pick option 2? While the majority of respondents preferred to deal with the matter privately, 37%, including 48% of experienced doctors, answered that they would speak to the supervising consultant. There was a high level of agreement as to why they would do so. Reason 1, 'You want to avoid potentially harmful consequences for patient safety', was both most frequently given and most frequently ranked as the most important reason. All but one respondent (99.5% of respondents) included this reason in their three choices of reasons and almost all ranked it first. The expert panel were of the opinion that this reason relates to the virtue of leadership or judgement amongst respondents. The next most frequently chosen was reason 4, 'NHS policy encourages whistleblowing – you would be following guidance' and 6, 'You will protect your colleague's reputation'. The expert panel were of the view that these reasons point to concerns with following the rules and with kindness, teamwork or forgiveness (reason 6). It is clear that, at least for this response to dilemma 5, when there are clear rules or policies regarding how professionals should behave, direct appeal to such rules is offered by a large number of respondents as the reason for their choice. It would therefore be unwise to lose sight of the influence that explicit rules do, on occasion, have on doctors' thinking about morally challenging situations. On occasion, rules clearly had an important effect on the thinking of many of our respondents. Chart 4 shows the results for all three career groups in choosing option 2 for dilemma 5.

DILEMMA 4:
A CONFLICT BETWEEN USING ONE'S JUDGEMENT, PRUDENCE AND RULES

In dilemma 4, respondents were presented with the following dilemma and options:

You have just taken over a single-handed general practice in a small, isolated community. You have always wanted a rural practice, and hope someday to marry and raise children there. Pat Cuthbert is an attractive, intelligent, level-headed patient whose family has lived in the community for generations. Pat is also a member of the hiking club you have joined. You have been treating Pat for some time for a skin condition, which appears to be clearing up. Although visits will continue to be necessary for monitoring, the patient is substantially improved. At the end of a visit, Pat smiles warmly and invites you to dinner, clearly showing an interest in being more than your patient.

What would you do?

OPTIONS:

1. Accept the invitation
2. Do not accept the invitation

REASONS:

	OPTION 1	OPTION 2
	You chose to accept the invitation. Please rank the three answers that best match the reasons for your decision	**You chose to decline the invitation. Please rank the three answers that best match the reasons for your decision**
1	You find Pat attractive	This is what is suggested by the *Good Medical Practice* guidelines
2	You are already seeing Pat socially	You want to preserve the professional doctor-patient relationship
3	You would like to start a serious relationship	Your career may be damaged if this gets out
4	Everyone you meet will be your patient; this dilemma will keep arising in a setting like this	Gossip and even scandal may ensue
5	There won't be any harm in it	You may end up in an awkward situation if the relationship does not work
6	You don't want to appear rude by refusing	Conflicts may arise with other patients

Most respondents (84%) indicated that they would not accept an invitation to become personally involved with a patient, although experienced professionals were slightly more inclined to accept such an invitation compared to starting undergraduates and completing graduates. 20% of experienced professionals reported that they would accept such an invitation as compared with 13% of students ($p<0.05$). Chart 5 (a–d) shows the results for all groups.
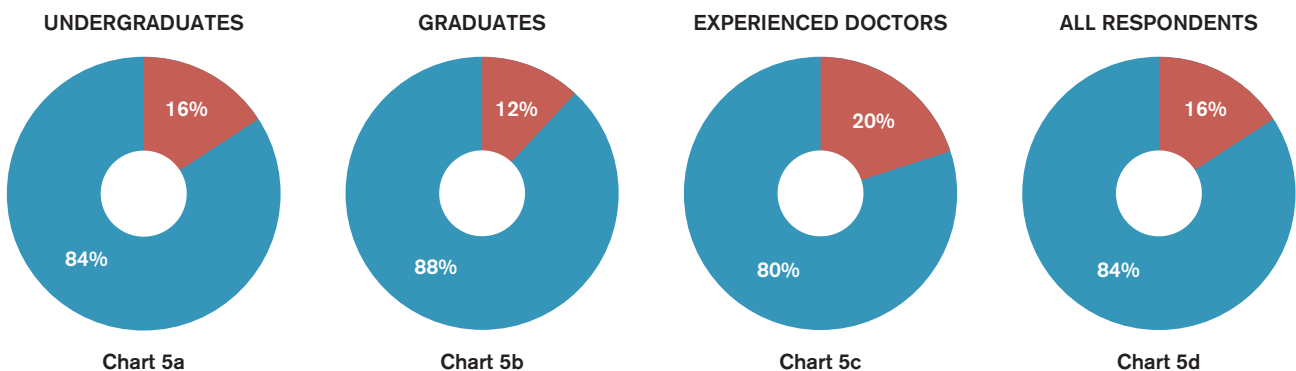
RESPONSES:

UNDERGRADUATES 16% / 84% Chart 5a

GRADUATES 12% / 88% Chart 5b

EXPERIENCED DOCTORS 20% / 80% Chart 5c

ALL RESPONDENTS 16% / 84% Chart 5d

Chart 6: Dilemma 4 Option 1 – All Respondents
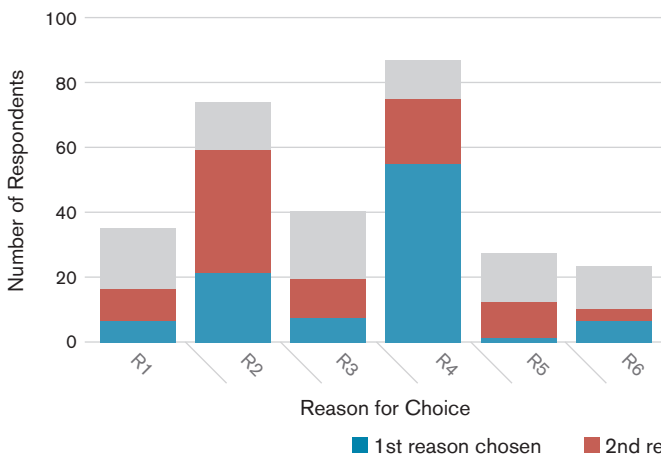
Chart 7: Dilemma 4 Option 2 – All Respondents

■ 1st reason chosen   ■ 2nd reason chosen   ■ 3rd reason chosen
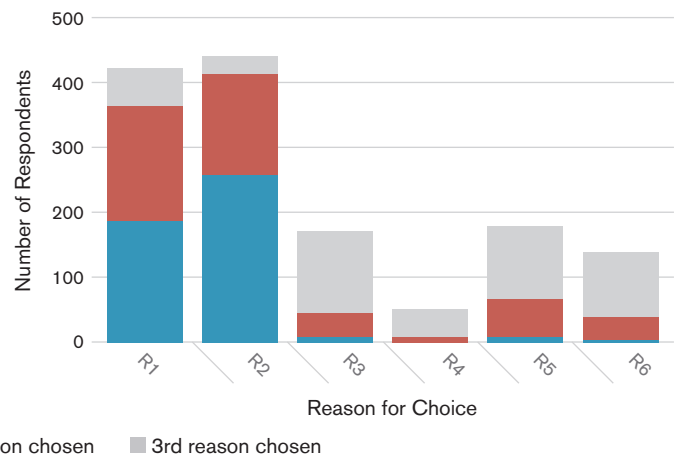
Amongst the 16% (or 88 respondents) who indicated they would become personally involved with a patient, reason 4, 'Everyone you meet will be your patient; this dilemma will keep arising in a setting like this' was the main choice and was also the first choice for most respondents. Reason 2, 'You are already seeing Pat socially' was the second most frequently chosen reason and reason 3, 'You would like to start a serious relationship' was picked third and was mostly selected as a third reason, suggesting that, while respondents found it a relevant consideration, it was not the most important. When evaluated by our expert panel, members thought these reasons, if given, would point to character strengths, such as: perspective or judgement (reason 4), kindness (reason 2) and hope (reason 3). Amongst respondents, men were significantly more likely to choose option 1 (that is, to take up the invitation) than women (p<0.05). Chart 6 shows the results for all three career groups in choosing option 1 for dilemma 4.

The reasons least often chosen were those to do with consequences or social expectations. Reason 5, 'There won't be any harm in it', and reason 6, 'You don't want to appear rude by refusing' were, respectively, the second least and least selected reasons.

The reason that most respondents gave as to why they would not become personally involved with a patient was reason 2, 'You want to preserve the professional doctor-patient relationship'. According to the expert panel, reason 2 points to the importance of prudence for the practitioner. Next most frequently selected was reason 1, 'This is what is suggested by the *Good Medical Practice* guidelines'. There was no clear third reason. Chart 7 shows the results for all three career groups in choosing option 2 for dilemma 4.

It is notable that one reason the panel of medical educators considered a virtue-based consideration (the good of the doctor-patient relationship) and one reason that the panel considered a rule-based consideration (what the GMC guidelines say) were very closely matched as to their importance. Indeed the GMC guidelines are firm on the matter; under 'Maintaining a professional boundary between you and your patient', *Good Medical Practice* states:

> *If a patient pursues a sexual or improper emotional relationship with you, you should treat them politely and considerately and try to re-establish a professional boundary. If trust has broken down and you find it necessary to end the professional relationship, you must follow the guidance in 'Ending your professional relationship with a patient'.*

That said, most respondents seem to see these two matters – the value of the relationship itself and the fact that the guidance says one thing or another – as strongly allied.

[**'CAN YOU BE A GOOD DOCTOR WITHOUT BEING A GOOD PERSON?'**
Anonymous]

DILEMMA 1:
A CONFLICT BETWEEN PRUDENCE, RULES AND RESPECT

In dilemma 1, respondents were presented with the following dilemma and options:

You are a GP, and are called out on a home visit to an 87 year old patient – Mr G. – who you have not met before. From his patient history, you see that he has an existing heart condition. You find him experiencing severe chest pains and shortness of breath, as well as low blood pressure. During your assessment, he appears to be deteriorating. You judge that he is having a heart attack, and that there is a strong chance he may die soon. You believe the best option would be to admit him to hospital immediately. However, despite extensive explanations from you, Mr G. is adamant he does not want to go to the hospital but wants to stay in his own home.

What would you do?

OPTIONS:

1. Admit Mr G. to hospital
2. Don't admit Mr G. to hospital, and arrange end of life care

REASONS:

	OPTION 1	OPTION 2
	You chose to admit Mr G. to hospital. Please rank the three answers that best match the reasons for your decision	**You chose not to admit Mr G. to hospital and arranged end of life care at home. Please rank the three answers that best match the reasons for your decision**
1	This is the best medical option for Mr G.	You should respect Mr G. by accepting his wishes
2	Mr G. is distressed and not in the best position to make this decision	Mr G. is quite likely to die anyway, so he may as well be allowed to stay at home
3	If you don't admit Mr G. and he dies, you might face consequences in the Coroner's Court	Trying to treat Mr G. against his own wishes isn't the best use of the hospital's resources
4	Your diagnosis may not be correct and you don't want to take the chance with Mr G.'s life	You are confident you will be able to give effective end of life care for Mr G. at home
5	If Mr G. dies you will feel guilty for not having done all you could to save him	This is the kindest option for Mr G.
6	This is what GPs are expected to do	Professional guidance states that if the patient is capable you should comply with their wishes

The dominant choice, for 82% of all respondents and for over 60% in each career stage, was option 2 'Don't admit Mr G. to hospital'. This option accounted for 63% of undergraduates, 83% of graduates and 90% of experienced professionals. Only 18% of respondents said that they would admit Mr G. to hospital. This option was chosen by 37% of the undergraduates, 17% of the graduates and 10% of the experienced professionals in the sample. Chart 8 (a–d) shows the results for all groups.
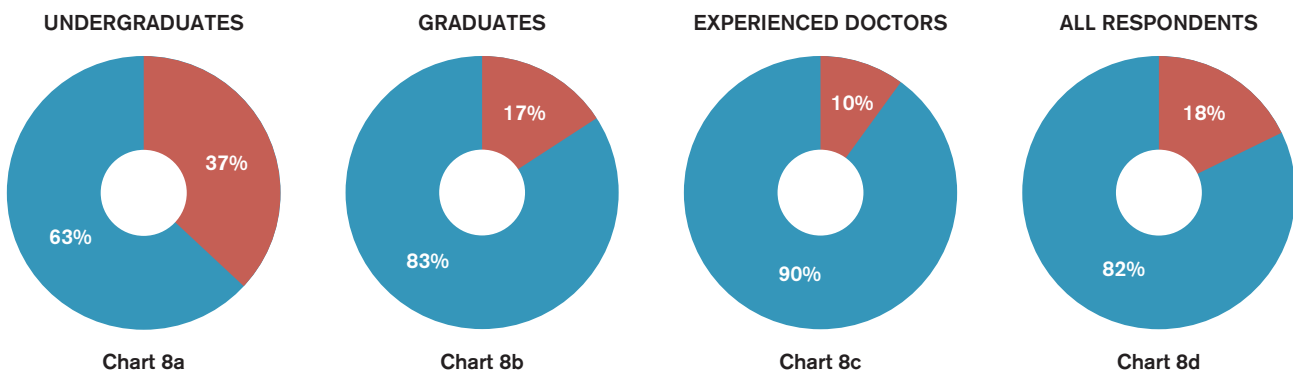
RESPONSES:

UNDERGRADUATES — 37%, 63%

Chart 8a

GRADUATES — 17%, 83%

Chart 8b

EXPERIENCED DOCTORS — 10%, 90%

Chart 8c

ALL RESPONDENTS — 18%, 82%

Chart 8d

Chart 9: Dilemma 1 Option 1 – All Respondents
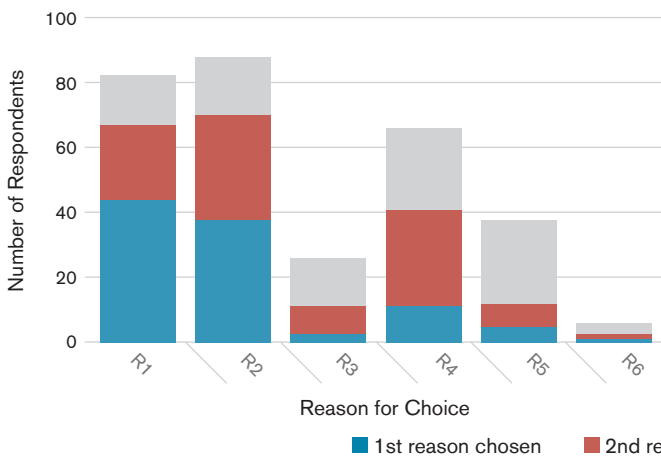
Chart 10: Dilemma 1 Option 2 – All Respondents

■ 1st reason chosen   ■ 2nd reason chosen   ■ 3rd reason chosen
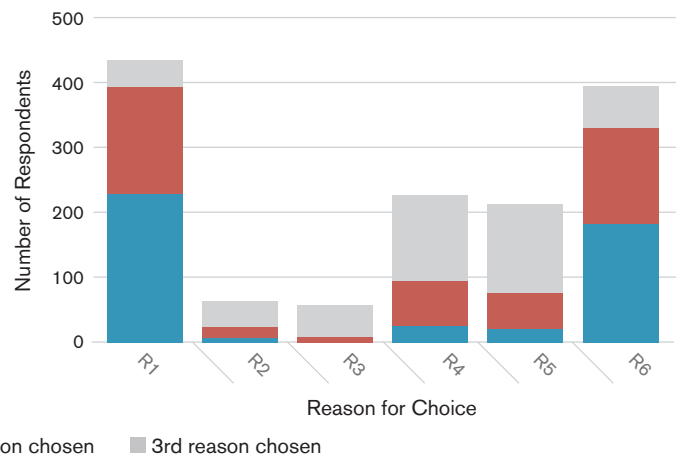
The most frequently cited reasons as to why respondents would admit Mr G. were reason 1, 'This is the best medical option for Mr G.' and reason 2, 'Mr G. is distressed and not in the best position to make this decision'. Together these two reasons represented 68% of all choices across all career stages. The expert panel thought that offering reason 1 for admitting Mr G. would point to the virtues of prudence, judgement, kindness or even leadership on the part of respondents, while offering reason 2 would point to judgement on the part of respondents. The reasons least often chosen were reason 6 'This is what GPs are expected to do' and reason 3 'If you don't admit Mr G. and he dies, you might face consequences in the Coroner's Court'. The expert panel regarded reason 6 as reflecting a rules-based approach (or at least a conventional approach) and reason 3 as reflecting a consequences-based approach. Chart 9 shows the results for all three career groups in choosing option 1 for dilemma 1.

Why did respondents pick option 2? The overwhelming majority of respondents – 82% – chose not to admit Mr G. to hospital. The most frequently cited reasons for this course of action were reason 1 'You should respect Mr G. by accepting his wishes' and reason 6 'Professional guidance states that if the patient is capable you should comply with their wishes'. The expert panel thought that offering reason 1 for not admitting Mr G. may point to virtues such as kindness or bravery. Offering reason 6 for admitting Mr G., on the other hand, points clearly to wishing to comply with a rule for action. Least frequently chosen were reason 3 'Trying to treat Mr G. against his own wishes isn't the best use of the hospital's resources' and reason 2 'Mr G. is quite likely to die anyway, so he may as well be allowed to stay at home'. Chart 10 shows the results for all three career groups in choosing option 2 for dilemma 1.

For those respondents who would not admit Mr G. to hospital, the matter of respecting Mr G.'s wishes and the wish to follow explicit guidance were very closely matched as to their importance. This is another example of where what could be called a virtue-consideration – in this case the kindness or bravery involved in taking the (more risky, in terms of Mr G.'s survival chances) option of not admitting Mr G. to hospital – and a consideration that is clearly rule-based, operate in concert. In this case, one may say, the virtue-consideration and the professional guidance that exists regarding abiding by patients' wishes are mutually reinforcing.

What do the dilemmas tell us?
As we have seen, we designed the dilemmas to understand how considerations of virtue interact with thinking about rules and consequences in explaining how medical students and doctors think about morally problematic situations. From the discussion above, it should be clear that it is possible to adopt the well-known moral dilemma approach to focus, not only on moral reasoning, but to explore additional considerations concerning virtue, such as motivational and emotional factors. The most fruitful way to think of moral dilemmas from a virtue-perspective is to conceive of such dilemmas as situations in which different virtues – and, sometimes, virtues and rules – come into conflict. According to traditional virtue ethics, that is exactly when phronesis, or good judgement, is most needed. So, being motivated by a virtue does not in itself guarantee moral rightness if it is not the virtue appropriate for the specific context.

As well as this interaction between virtues, rules and consequences, we were also interested in establishing which virtues play an important role in shaping our respondents' reactions to the moral dilemmas. Doing so was an important part of our exploratory aims with this research. The results of the dilemma

section allowed us to look at the issue of which virtues play a role in doctors' thinking about moral dilemmas, in two ways.

Firstly, in evaluating the moral dilemmas, the expert panel mapped the reasons for action provided to specific virtues: the expert panel indicated which of the 24 virtue words from the Peterson and Seligman classification (also used in sections 1 and 3 of the survey) one could associate with giving a certain reason for acting one way or the other in a dilemma situation. In specifying which virtues are reflected by which reasons, our expert panel drew very heavily on only a small number of virtues out of the list of 24. When 'mapping' virtues to reasons, the expert panel linked a reason for action with a specific character or virtue term, the frequency of each is shown in Table 6.

Table 6: Character Strengths Used by the Expert Panel in the Dilemmas

Character Strength	Number of times the expert panel mapped this strength against a particular reason for action
Judgement	21
Kindness	13
Fairness	10
Prudence	10
Leadership	8
Perspective	8
Bravery	6
Teamwork	4
Social intelligence	3
Hope	3
Self-regulation	2
Curiosity	2
Humility	1
Perseverance	1
Appreciation of beauty	1
Love	1
Forgiveness	1

(The remaining virtues from the list of 24 were not used by the expert panel at all).

This indicates that, in their thinking about the moral dilemmas, the expert panel saw especially the virtues of judgement, kindness, fairness, prudence, leadership and perspective as being highly relevant matters that could potentially shape a doctor's thinking about a range of moral dilemma situations. This offers independent confirmation of our finding reported above (see section 4.1) regarding the importance of the virtues of judgement, kindness, fairness and leadership in a good doctor.

Next, we examined which of the reasons associated with these virtues were most frequently picked by respondents. Table 7 illustrates the number of times reasons mapped to particular character strengths were selected by respondents (1) in their top three choices and (2) as their first choice.

This indicates again, independent of our findings reported in section 4.1, that our respondents were also inclined to select the reasons associated with the virtues of judgement, kindness, fairness and leadership as the best reasons for taking a particular course of action.

Table 7: Character Strengths Selected by Respondents in the Dilemmas

Character Strength	Number of times an item mapped to this strength was selected by respondents in the top 3 choices	Number of times an item mapped to this strength was selected by respondents as the top choice
Judgement	13	6
Kindness	11	6
Fairness	7	3
Leadership	6	3
Prudence	4	3
Bravery	4	1
Perspective	4	1
Social intelligence	2	1

(Reasons associated with the remaining virtues from the list of 24 were not selected by respondents).

Three different sources of information, then, point to the importance of the virtues of judgement, kindness, fairness and leadership in the ethical practice of medicine:

- Respondents' reported views of the character of the 'ideal' doctor;
- A group of medical educators' judgement of which virtues are in play in moral dilemma situations in medicine; and
- Respondents' choices amongst the reasons for acting one way or another in the situational judgement tests on the e-survey.

Overall, the responses to the dilemmas point to a widespread reliance not only on virtue-based considerations, but considerations involving a small group of commonly favoured virtues. Rule-based considerations are also common, often complementing rather than contradicting virtue-based ones. Considerations of mere consequences or utility are, however, rare.

4.3 VIRTUES IN CONTEXT

We have so far examined the character traits medical students and doctors use to describe themselves and the 'ideal' doctor and tentatively examined how thinking in terms of virtues impacts on medical practice. The exercise of professional judgement does not occur in isolation however, but in a wider social, political, economic and cultural context. These contexts highlight the importance of the tacit and personal dimensions of medical expertise in the 'real world' of clinical situations (Bruce, 2007). This section examines the influence of the organisational or work environment and therefore, is based solely on responses from experienced doctors as the other two groups were either at the beginning or end of their initial medical education. Our analysis draws on section 4 of the e-survey which consisted of a 15-item questionnaire

exploring practising doctors' views of their workplace. Factor analysis of responses to 15 items identified four factors, which we have named 'autonomy', 'involvement', 'support' and 'challenge'. Interviews with participants also explored the influence of the workplace and medical regulation emerged as an additional theme. By exploring these five themes, we consider here which features of the workplace influence virtuous practice most.

4.3.1 Autonomy

Two questions on the e-survey ('I am able to act in the best interests of my patients' and 'I have the resources to do my work to a standard I believe is right') were found to factor together. We called this factor 'autonomy' (see Table 8).

Of the 276 experienced doctors in the sample, 68.5% indicated that they practice with autonomy sometimes to mostly and a further 20.3% mostly to always. Given complaints that are often made about doctors' loss of autonomy, these are interesting results. The interview data yields insight into how this autonomy is understood in the context of contemporary practice. As one experienced doctor remarked:

It used to be that doctors were gods. Now they have to conform to more national guidelines and if they don't, they're more likely to be caught out than they would have been years ago. (Experienced doctor)

It seems that many doctors perceive a bigger picture surrounding a change in the notion of autonomy within which they still feel capable of using their professional judgement:

I do feel that we're not allowed to use our judgement as much as we were previously. I do feel that the guidelines and policies are leading the way much more now… we have

a lot of prescribing guidance, as I'm sure you're aware – a lot of places do – and there are a couple of medications that are classed as specialist only prescribing. But actually I do, in certain cases, prescribe them when I feel it is appropriate and I feel confident to actually undertake that prescribing and take the responsibility for it. (Experienced doctor)

Another participant acknowledged that doctors have lost some 'stand-alone' autonomy but qualified this loss in terms of gains in collegiality:

Less autonomy, which often people say that that's a bad thing, but actually I think a team approach to complex problems is really helpful. One of the things that is difficult when you qualify, particularly if you become a consultant or a GP, or once you reach a GP principal position or a consultant, is that you're expected to know everything and do everything and nobody ever watches you or listens to you in your practice ever again and therefore it's very easy to lose track and if you're making mistakes, not to necessarily realise them. (Experienced doctor)

It seems that what some doctors feel they may have lost in their ability to exercise autonomous judgement, has been compensated for in other ways and has allowed the foregrounding of other virtues, in particular teamwork. As we saw in section 4.1 above, the ability to work in a team stood out as an important virtue both in doctors' own conceptions of themselves and their conception of the 'ideal' doctor.

4.3.2 Involvement
We have already noted the strength of experienced doctors' and medical students' identification with their work role and the e-survey showed experienced doctors' emotional involvement with their work as positive. Three questions in the e-survey factored together: 'I am emotionally involved in my work'; 'I have the feeling of doing useful work'; and 'I am motivated to work to the best of my ability'. We named this factor 'involvement' and experienced doctors reported a high degree of involvement in their work (see Table 9).

Experienced doctors in the sample tended to report high levels of involvement in their work and 98.2% of doctors reported that they are sometimes to mostly, or mostly to always, emotionally involved in their work; only 1.8% reported little or low emotional involvement in their work.

The interviews explored involvement in work in more depth, probing what influences in

the workplace enabled respondents to be involved in their work and what inhibited this involvement. Of the supporting factors, by far the most important was supportive colleagues, one noting:

I think the team that I'm in is fab. I like my partners all very much and I like the team that we've – you know, that we employ around us. (Experienced doctor)

Another item frequently mentioned was a supportive home environment. Indeed, one experienced doctor mentioned them as equivalent:

I think support from colleagues is a really, really important thing and also, therefore, support at home in terms of being – you've got to be happy at home to be able to do your job properly… (Experienced doctor)

Issues that inhibited involvement included, above all others, workload and a lack of time to provide the level of care doctors felt appropriate:

I guess time is always really the one you hear commonly mentioned, we have to battle against it, don't we? There are not enough hours in the day to do everything else to the true high standard that I would want to. (Experienced doctor)

However, the right level of support seemed to mitigate these pressures:

I remember having sort of upwards of 50 patients that I had to see in one day. You're

still seeing them in the afternoon, you can't do a good job, but actually, if you can come home to someone who's a human being and who actually loves you and doesn't sort of just say, yes, I know… because I come home to someone who actually has a life outside of medicine, you know, who can sit there and understand, but actually can also tell me that there's a life outside of the stress and all the things that go on at work, but also listens to the facts of what I do. (Experienced doctor)

4.3.3 Support
If the support of colleagues and family is particularly important to sustain doctors' emotional involvement in their work, what do doctors think of the level of support that they receive?

The following five questions on the e-survey factored together: 'My colleagues help and support me'; 'I am not treated fairly'; 'I am able to apply my own ideas in my work'; 'I am able to influence decisions that are important for my work'; and 'I feel at home in my workplace'. All of these questions indicate the degree to which respondents find their workplaces to be supportive and this factor was labelled 'support'.

In contrast with levels of emotional involvement in their work, there was less certainty about the workplace as a supportive environment. As shown in Table 10, 65.9% of doctors saw their working environment as sometimes to mostly supportive, with 24.6% viewing it as mostly to always supportive, and 9.4% saw their working environment as rarely providing support (see Table 10).

Table 8: Experienced Doctors' Views of the Degree of Autonomy they are Accorded

Factor 1: Autonomy N=276	Never to Rarely	Rarely to Sometimes	Sometimes to Mostly	Mostly to Always
Mean=3.86	1–2	2.1–3	3.1–4	4.1–5
%	1.1	10.1	68.5	20.3

I am able to act in the best interests of my patients
I have the resources to do my work to a standard I believe is right

Table 9: Experienced Doctors' Emotional Involvement in their Work

Factor 2: Involvement N=276	Never to Rarely	Rarely to Sometimes	Sometimes to Mostly	Mostly to Always
Mean=4.10	1–2	2.1–3	3.1–4	4.1–5
%	0	1.8	52.9	45.3

I am emotionally involved in my work
I have the feeling of doing useful work
I am motivated to work to the best of my ability

Table 10: Experienced Doctors' View of the Supportiveness of their Work Environment

Factor 3: Support N=276	Never to Rarely	Rarely to Sometimes	Sometimes to Mostly	Mostly to Always
Mean=3.76	1–2	2.1–3	3.1–4	4.1–5
%	0.7	8.7	65.9	24.6

My colleagues help and support me
I am not treated fairly (scores reversed)
I am able to apply my own ideas in my work
I am able to influence decisions that are important for my work
I feel 'at home' in my workplace

Why doctors seem less positive about support in their workplace was followed up in interviews, where issues such as targets and managerial pressures appeared to influence their sense of supportiveness in the working environment. One GP explicitly blames service reconfigurations and funding cuts:

Support from your partners, very high educational standard in the practice that I work, in general a very good relationship with the patients, I think it's been hindered by NHS reconfigurations and current disinvestment in primary care. (Experienced doctor)

An exchange with a senior doctor recounts how (s)he gave up a senior clinical management position because of managerial pressure:

I learnt whilst I was [deleted, job role], you've got to do what is right, whatever other people around you say and, if the people around you don't support you in doing what's right, you just stop doing it. You know, I mean, in the end, I stopped being the [job role] because the whole thing became incompatible with my value set.

Interviewer: Really? I mean, could you say something briefly about that?

Well, this is a few years ago now, but it was largely about managing fellow clinicians and I was told I was too nice, basically. I had to be more dictatorial.

Interviewer: And if you had been, what end would that have achieved?

Well, it would have perhaps, in the short term, got the outcome, the numbers would have stacked up and the target would have been hit, but … [continues]… if my relationship with my colleagues was so damaged as a result and I was therefore sort of excluded from, and I had behaved in a way that was persistently incompatible with my natural style, that was just too high a price really. (Experienced doctor)

4.3.4 Challenge

The message from this senior doctor about managerial pressures is significant as it illustrates how the workplace can sometimes force people, including doctors, to act against their moral character. The e-survey included five questions in this area that factored together: 'My work involves tasks that are in conflict with my personal values'; 'My work requires that I hide my feelings'; 'I experience stress'; 'At work it is difficult to do the right thing'; and 'I do not have time to do my work to a standard I believe is right'. All these questions probed whether today's medical workplace presents such challenges as to make doctors act out of character, and this factor was labelled 'challenge'.

We found that 7.6% of doctors only rarely experience such challenge and 70.3% experience such challenge only rarely to sometimes. However, a not insubstantial number (21.0%) said they experience challenge to their personal moral character sometimes to mostly and 1.1% mostly to always (see Table 11). Amongst these challenges is how to respond to pressures of time, targets and budgets:

There have been times in the past where the way that things have been structured and the way funding has been, I felt that I've not been able to give patients the service I want. There was a time in [deleted] where, basically, orthopaedics didn't exist, there was such a long waiting list. Urgent cases were a year and I felt very frustrated that if I

felt somebody needed an orthopaedic referral for something, that I was being blocked from that. (Experienced doctor)

And

[When] you realise you're making decisions based on cost because you think: surely we're just going to do exactly what's the best thing for the patient. And then the reality of actually – no, you need to actually look at what the costs are and that can be quite frustrating, so I suppose it's costs of tests that you want to do or costs of treatment, that's something that can be quite frustrating. (Experienced doctor)

The interplay between organisational environment and virtues was seen by some as having a detrimental effect on individual character qualities. One respondent commented on the consequences of time pressures on their ability to show patients compassion:

Actually it is quite easy, I think, in the sort of NHS we have now, you know, you have huge numbers of patients, you have very little time and actually it's quite easy to lose your compassion. It's not just compassion for the patients, but compassion for yourself, compassion for your colleagues and just the stress is such that actually you're not doing the job that you should be doing and actually, there's an interesting question about whether you can, given the number of patients. (Experienced doctor)

4.3.5 Regulation

A fifth theme associated with the workplace was medical regulation. Field speaks for many when he holds that 'health care professionals may feel that they spend more time complying with rules that direct their work than actually doing the work itself' (Field, 2008: 607). Indeed some, for example Schwartz and Sharpe (2010), hold that over-regulation of medical practice can be counter-productive. In our interviews, we investigated views of the guidelines that exist for ethical medical practice in the UK today.

Table 11: Experienced Doctors' Perceptions of Challenge to Living out their Character

Factor 4: Challenge N=276	Never to Rarely	Rarely to Sometimes	Sometimes to Mostly	Mostly to Always
Mean=2.75	1–2	2.1–3	3.1–4	4.1–5
%	7.6	70.3	21.0	1.1

My work involves tasks that are in conflict with my personal values
My work requires that I hide my feelings
I experience stress
At work it is difficult to do the right thing
I do not have time to do my work to a standard I believe is right

The UK GMC's publication *Good Medical Practice* (GMC, 2013) provides guidance on the standards of professionalism that can be expected of doctors. While the e-survey contained no specific questions about the impact of regulation on doctors' ability (or not) to exhibit good moral character, the interviews conducted with medical students and doctors explored this matter thoroughly.

Analysis of the interviews demonstrated an important shift in attitude towards the rules regulating doctors' professional conduct. First year students tended to regard *Good Medical Practice* as a document to be obeyed at the risk of legal action. As one medical educator summarised it:

…the first years sometimes come to me and say, 'The GMC says…' it's 'these are the things that I know I have to do or not do', and it isn't internal at any way, shape or form at that point. (Medical educator)

However, graduating students tended to become aware that *Good Medical Practice* contains only partial guidance that does not clearly cover all cases, as this graduating medical student expressed:

I was actually reading through it yesterday, it does, but I think what I like best is you have more, I don't know if there's access to sort of examples, where you put the guidelines into practice, 'cause sometimes when you're reading something through, it's difficult to gauge exactly what they're trying to get and to sort of think in your head, oh, if this now happened, is this what they'd want me to do… (Graduating medical student)

Practising doctors, on the other hand, either tended not to have read the document in many years or to regard its advice as mostly indicative. As one medical educator held:

I think the GMC's guidance is there as a kind of bottom line I think rather than, I mean, if you just went to medical school and spent 5 years just reading GMC guidelines, it's not going to teach you how to be a good doctor. I think it's there to tell you what the boundaries are rather than as being a guide as to how to practice. And as I say, the guidance on how to practice doesn't exist, because it's age old, it's watching previous generations of doctors, working alongside them and learning it by experience really. (Experienced doctor)

As a group, experienced doctors were united in the view that professional guidance is there to guide medical practice, but should not replace professional knowledge and the virtue of moral judgement. The extent to which it is hard to codify this professional knowledge was illustrated well by one medical educator:

When you're looking at the GMC's guidance, a lot of it, it's just detailed, but yet actually if you were a doctor and you had a particular scenario, very often that scenario is not covered, so it's not, even though it's quite long, it's not actually that precise… They also use Good Medical Practice, you know those interactive case studies… [continues] and then they say at the end, but don't take this as any statement that this is indicative of the law and you think, well, how flipping helpful is that, not at all. (Medical educator)

The subject of rule-based versus virtue-based approaches to medical ethics is complex and our conclusions from the interviews do not in themselves contain an argument against elements of current guidance. What they illustrate instead is doctors' realism about the limitations of defining good medical practice in a single document or, indeed, in scenarios and cases. Helpful as these are, most doctors are aware how practising medicine professionally is learned over time in a professional context from practising clinicians. This makes it that much more important that the organisational context of the health service is managed with an awareness of the moral messages it conveys to (especially) junior doctors entering their first years of practice.

4.4 OVERALL FINDINGS

The project considered the role of character in ethical practice in medicine from three broad perspectives:

- what medical students and practising doctors say about their own character, the character of their colleagues and the character of the 'ideal' doctor;
- what role character plays in how medical students and practising doctors respond to real moral problem situations in medicine; and
- how the environments in which doctors work enable or constrain them in exhibiting good moral character.

Notable findings include:

1) Respondents across all three career stages hold that the following virtues are important in the good doctor:
   - Fairness
   - Honesty
   - Judgement
   - Kindness
   - Leadership
   - Teamwork

2) Respondents across the three career stages rate their own character highly on fairness, honesty, kindness and teamwork, but have a lower opinion of the degree to which they demonstrate:
   - Judgement; and
   - Leadership

3) In moral dilemma situations, the importance given to each of these virtues can be illustrated, but varies according to the context. In dilemma situations, where there exist explicit rules for how doctors should conduct themselves, these explicit rules can play an important role in doctors' reasoning.

4) The virtues found to be most important in the six dilemmas posed on our survey were: judgement, kindness, fairness and leadership.

5) Important factors to do with the working environment that may influence doctors' ability to demonstrate good moral character were found to be:
   - autonomy;
   - emotional involvement in their work;
   - support from colleagues; and
   - the degree to which the workplace is in accordance or conflict with their own moral character.

There is much that is positive about these findings. Firstly, the top six professional virtues as identified by respondents seem appropriate for the profession. Secondly, there is a high level of agreement about the importance of these six virtues across the career grades. Thirdly, four of the top six are also in the top six personal virtues, which may suggest that recruitment into the profession is getting quite a lot right. There are gaps however (for instance in the extent to which respondents report that they possess the strengths of judgement and leadership), which raise questions for education and training.

5 Implications for Medical Education

In this section, we interpret the most important findings from the previous section and discuss the implications of these findings for professional character formation in medical education and practice.

5.1 HOW IS CHARACTER LEARNED IN MEDICAL EDUCATION AND PRACTICE?

In the past, medical education tended to focus on technical knowledge and competencies, whilst assuming that other necessary skills (such as professionalism), would be acquired by practice rather than tuition (Gelhaus, 2011). However today, there is broad agreement that 'medical education is about more than acquiring an appropriate level of knowledge and developing relevant skills', and that, 'medicine students need to develop a professional identity' (Goldie, 2012: 641). A survey of ethics teaching in UK medical schools found that most regard instilling ethical behaviour, understanding of ethics and understanding of medical law as important aims and that most regard themselves as succeeding in these endeavours (Mattick and Bligh, 2006: 182). Failing one's ethics course however, was found not to be a bar to graduation in 15 of the 22 medical schools surveyed (Mattick and Bligh, 2006: 181). Whilst there is some distance to travel, until medical ethics education occupies the central position it deserves in medical education in the UK, UK medical schools understand the importance of ethics education. Especially with regard to integrating ethics education with the rest of the medical school curriculum, both vertically (throughout the years of study) and horizontally (by giving attention to medical ethics not only in a dedicated course but across the curriculum), Mattick and Bligh found that the UK is 'ahead of the game, compared with the US and Canada…' (Mattick and Bligh, 2006: 184).

The matter of integrating ethics with the rest of the curriculum is especially important from the perspective of virtue ethics. Virtue ethics from Aristotle (*Nichomachean Ethics, Politics*) to today (Annas, 2011; Snow, 2010) stresses how moral character formation takes place through practice in a given context over time. In this context, the mode in which students and junior doctors learn is often tacit – what, exactly, professional practice amounts to is often not a matter that is stated in curriculum documents or course outcomes, but is unstated. Indeed, in

medical education, the power of the 'hidden curriculum' (Hafferty and Franks, 1994) is often stressed. Hafferty and Franks hold that medical training seen in the round is a form of moral training, in which the formal curriculum only plays a small part; more important to how medical students will eventually practice is the 'cultural milieu' of the medical school (Hafferty and Franks, 1994: 861).

This finding about the importance of the 'hidden curriculum' was borne out by the findings from our study in two ways. Firstly, in the interviews, medical students stressed the great importance of clinical placements in becoming aware of how medicine is best practiced. Secondly, analysis of interview material demonstrated a real change of the attitudes of interviewees across the three career stages to codes of medical ethics and, most importantly, to the GMC's core ethical guidance, *Good Medical Practice*. Whereas first year students interviewed tended to regard *Good Medical Practice* as a clear set of rules for conduct, graduating students had a more nuanced stance, and experienced doctors tended to regard *Good Medical Practice* as giving only partial guidance that must be understood in the light of experience. This shows how the reality of learning how to practice medical ethics is not a matter of being taught a code, but of a 'hidden curriculum' that exists largely in practice and example.

Furthermore, the example of moral exemplars or role models is of great importance to the development of character. Cruess *et al.* (2008) and Campbell *et al.* (2007) demonstrate the importance of good role models in professional education in medicine. Findings from our interviews also illustrate how important medical students and practising doctors find good role models. Medical students reported good role models as being one of the most important factors (next to a supportive team – arguably related) that enables them to exhibit a positive character. Moreover, practising doctors and medical educators all stressed the importance of role-modelling in effective professional education in medicine.

The findings of this study, then, support and reinforce the current trends in the education of medical ethics and reinforces the importance of the integration of ethics education with the rest of the curriculum, the importance of role

modelling and the importance of ensuring that the 'hidden curriculum' is aligned with the aims of instilling professional conduct in medical students and young doctors.

5.2 THE CONTENT OF THE MEDICAL ETHICS CURRICULUM

While our study chimes with the theoretical understanding of processes of medical education, development of (1) medical ethics curricula and (2) medical ethics assessments is lagging behind.

The giving of serious attention to the medical ethics curriculum in the UK can be traced to the Institute of Medical Ethics's (IME) *Pond Report on the Teaching of Medical Ethics* (Institute of Medical Ethics, 1987) and to the GMC's report *Tomorrow's Doctors: recommendations on undergraduate medical education* (1993) that contained much on education in ethics and professionalism. In 1998, the IME and GMC worked together to develop a model core curriculum for teaching medical ethics and legal issues to undergraduate medical students (Ashcroft *et al.*, 1998). The model core curriculum was updated in 2010, following consultation with medical schools, practitioners, the GMC, the Royal Colleges and other relevant bodies.

On their webpages devoted to the 2010 core curriculum, the IME states:

The ethics component of the core has two main complementary purposes:
- *Creating 'virtuous doctors'*
- *Providing them with a skill set for analysing and resolving ethical problems (though these are sometimes seen as being in tension with each other).*

In section 2 above we saw that, despite the fact that virtue-based approaches to medical ethics receives great attention in the literature, empirical study of medical ethics tends – by a large margin – to be deontological or cognitive in its orientation. Largely the same appears to be the case with the IME core curriculum (despite the reference to 'virtuous doctors' above).

In a report on the updated curriculum, Stirrat *et al.* (2010) stressed the importance of shaping medical students' character *in addition* to

instilling knowledge of ethical principles. For instance, Stirrat *et al.* quote Rhodes and Cohen with approval to the effect that 'as medical educators we have to help our students to understand their professional responsibilities *and* be people who have the requisite character…' (Stirrat *et al*, 2010: 55, quoting Rhodes *and* Cohen, 2003) (emphasis added). Moreover, the authors of the core curriculum clearly stipulate that next to critically reflective understanding of 'a necessary core of knowledge, skills, attitudes and behaviour', medical students should 'be able to demonstrate in practice an understanding of' a number of additional attitudes and practical skills (Stirrat *et al.*, 2010: 56). The writers of the core curriculum are clearly aware that:

- ethical medical practice requires more than simply knowledge of medical ethics and law; but
- has much to do with attitudes and behaviour in practice.

Despite this clear awareness of issues to do with a doctor's character as a professional, the core curriculum does not give a particularly virtue-based account of what medical students in the UK should study, or of what should be expected of doctors in terms of their moral character. It may be the case that educators are not convinced that instilling virtues increases the probability of morally right conduct in doctors. As Drane (1995: 32) says: 'it is one thing to make a generic argument for the place of character and virtues in medical ethics and a more difficult thing to argue convincingly for those specific character traits which make a good doctor'.

Most of the content of the core curriculum deals with an understanding (sometimes a critically reflective understanding and sometimes an understanding in practice) that students should demonstrate of matters such as:

- Professionalism
- Patients' rights
- Consent
- Capacity
- Confidentiality
- Justice
- The rights of children
- Mental health
- The beginning of life
- The end of life
- Medical research

The words 'character' and 'virtue' are not mentioned in the core curriculum at all, but are only alluded to in references to 'skills, attitudes and behaviours' and matters regarding which students 'should be able to demonstrate in practice an understanding of'[20].

Next to the core curriculum, the IME also published *Medical Ethics and Law: a practical guide to the assessment of the core content of learning* (Fenwick *et al.*, 2013). The practical guide quotes the GMC's guide *Tomorrow's Doctors* to the effect that the medical graduate will be able to:

> *Be polite, considerate, trustworthy and honest [and] act with integrity.*
> (Fenwick *et al.*, 2013: 1)

These are clearly virtues that the GMC expects of medical students. The practical guide is also built around the idea that there is a difference (in ethics, like in clinical practice) between students having knowledge of ethics and the progressively harder matters of whether they know how to practice, can show how to practice or in fact do practice in an ethical way (Fenwick *et al.*, 2013: 9). In order to assess the application of the principles of medical ethics and law in practice, the practical guide suggests greater use of Objective Structured Clinical Examinations (OSCE's) and observation methods, specifically 360-degree assessments. In their examination of forms of ethics assessment, Campbell *et al.* (2007) advocate the same methods (OSCE's and 360-degree assessments) for demonstrating clinical ethical competency in action.

However, both these authors and others representing a more positive view of medical students' moral development through teaching and learning interventions, acknowledge the difficulty in accurately assessing virtue or professionalism. Jha *et al.*'s (2007) systematic review of studies from the USA and the UK found that few studies are able to robustly illustrate a change in attitudes towards professionalism as a result of teaching interventions. This is due in no small part to the difficulty – discussed above – of constructing psychometrically rigorous measures of students' attitudes towards professionalism and their professional values, which makes it difficult to draw firm conclusions about efficacy or ethics or professionalism education (Eckles, 2005: 1146). It appears that assessment of the core medical ethics curriculum in the UK has some way to go before it can robustly demonstrate that the teaching of medical ethics results in more ethical and professional practice.

5.3 THE RELEVANCE OF THE VIRTUES AND VALUES IN MEDICAL TRAINING

Medical ethics educators in the UK today clearly understand the importance of character in medical ethics. Virtue ethical approaches to the study of medical ethics have had great impact in the field, and such approaches are increasingly making themselves felt in approaches to medical ethics education. However, as we have shown above, empirical study of medical ethics still tends to be informed by principles-based approaches to medical ethics and there is a lack of standardised measures to assess the character or virtue-driven aspects of medical students' professionalism. For this reason, virtue ethics has, as yet, failed to gain much ground in the shaping of:

- medical ethics curricula (such as the IME core curriculum for medical ethics); and
- assessments used in medical ethics education.

To recapitulate, our study constitutes the first large-scale empirical study of medical ethics from a virtue-perspective in the UK. The study was not aimed at designing psychometrically valid measures of medical virtue. Rather, it aimed to explore which virtues influence medical practice, how the virtues influence medical decision-making and how context enables or inhibits the display of medical virtue. Our results can inform the development of medical ethics curricula and assessments in the ways listed below.

- Results from our study regarding views of the 'ideal' doctor illustrate which virtues medical students and practising doctors find important. The virtues of fairness, honesty, judgment, kindness, teamwork and leadership can form the focus of character education interventions in medical education. By the same token, these virtues deserve to be studied more closely in a medical context.
- Results from our self-report study of medical students' and doctors' character strengths can serve as a baseline for later comparative studies. Knowing what medical students at two different stages and experienced doctors at four sites in the UK report on their own character enables one to make comparisons with others, or, indeed, begin to estimate the effects of interventions with comparable groups.
- With our situational judgement tests, we attempted for the first time to design moral dilemma tests from a virtue perspective. These designs can be further developed to chart character development in medical students (rather than simply development in moral reasoning ability).

This study has helped show what is good in medical ethical education (and worth learning from), identified some omissions, questioned the balance between different ethical approaches and, tentatively, looked at how scenario approaches may have something to contribute.

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[20] Another example of a core curriculum for medical ethics is the UNESCO Bioethics core curriculum. This core curriculum is a deontological, rights-based curriculum (being based on the Universal Declaration on Bioethics and Human Rights).

6 Recommendations

6.1 INITIAL EDUCATION IN PROFESSIONAL ETHICS

Medical ethics curricula are predominantly focused on rule-based approaches, yet experienced doctors show a greater readiness to resolve dilemmas drawing upon aspects of character and judgement with rules in a supporting role. That character and judgement inform ethical decisions needs to be taken into account in initial medical training. In this regard, *medical students* need to:
- Understand the importance of virtue over and above moral reasoning alone.
- Become virtue literate and be able to see themselves and others in character terms.
- Be given opportunities to develop their character during medical training.

Medical educators need to:
- Appreciate the importance of role modelling in the light of virtue ethics.
- Grasp the difficult balance between formal and informal curricula and realise the importance of the 'hidden curriculum' in developing character. In order to make doctors' character growth more tangible, the hidden part of curriculum must be made more visible, for example by giving clear feedback regarding matters that are usually unspoken.

- Begin the process of developing valid, reliable and fair means to assess medical students' and doctors' moral character. Without attention paid to assessment, no-one will be in a position to know whether character development in medical school has been successful.

In *general:*
- Educators, regulators and ethicists must bear in mind that ethics education is an ongoing process and cannot be finished once and for all at medical school.

6.2 ETHICS AND THE WORKPLACE

Doctors see their workplace as providing them with autonomy and positive emotional involvement. On the other hand, some doctors report experiencing challenge to their personal values in the workplace and not all doctors experience the same level of support from colleagues.
- Through the influence of role modelling, the culture of the workplace is formative of young doctors' character. Making this 'hidden curriculum' more explicit by discussing it openly with colleagues and giving clearer feedback to students will make character and virtue more visible as an influence on practice.

6.3 THE REGULATORY AND PROFESSIONAL MESSAGE

Medical regulation of itself does not determine ethical medical practice. As the findings show, guidelines for good medical practice are interpreted in context. In this, character (and most notably good judgement) plays an increasingly important role as doctors become more experienced. In most medical regulation however, an understanding of rules or principles for conduct dominates. While some attention is given to character, this is rarely systematic.
- Clear space needs to be made in regulatory terms for what is expected of a doctor's moral character next to what is expected in terms of compliance with rules.
- The dilemma approach to making clear how ethical dilemmas occur in context deserves to be developed. Rather than serve only as examples of guidance in practice, such dilemmas deserve to be developed as teaching tools and assessment tools.
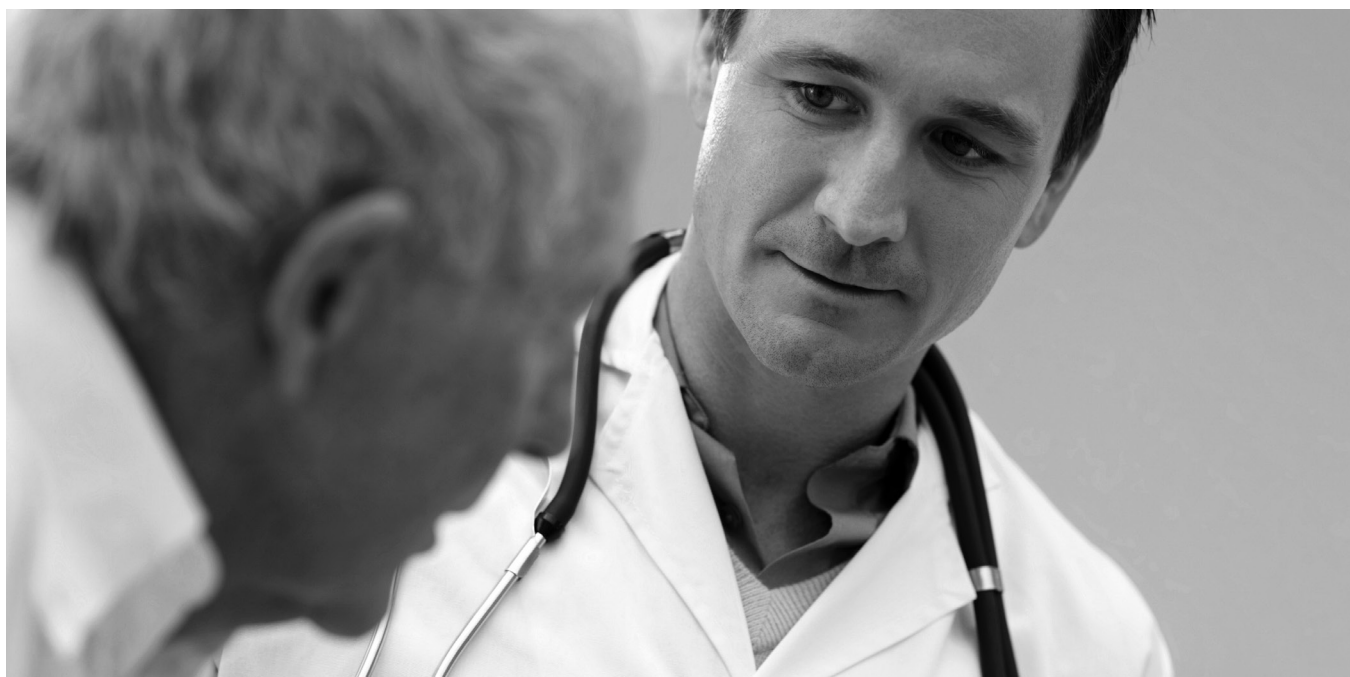
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Appendices

Appendix 1: Total Number of Survey Respondents by Career Stage and Religion

			Career stage		
			UG students	Graduate students	Experienced doctors
Religion	Buddhism	%	0.8	0.0	1.5
	Christianity	%	**40.2**	**37.3**	**50.5**
	Hinduism	%	6.6	7.2	4.0
	Islam	%	12.3	3.3	3.6
	Judaism	%	0.0	2.0	3.3
	Sikhism	%	2.5	0.0	0.4
	Other	%	0.0	3.3	4.4
	None	%	**37.7**	**46.4**	**32.4**

Appendix 2: Members of the Expert Panel

Dr Kamal Nathavitharana	Consultant Paediatrician, Worcestershire Acute Hospitals NHS Trust
Mr Jonathan Pepper	Consultant in Obstetrics and Gynaecology, Walsall Hospitals NHS Trust
Dr Rachel Upthegrove	Clinical Senior Lecturer, Department of Psychiatry, University of Birmingham Medical School
Professor Michael Gammage	Professor and Vice Dean for Medical Education, University of Birmingham Medical School
Professor Kate (Cathryn) Thomas	Vice Dean, University of Birmingham Medical School
Professor David Fitzmaurice	Deputy Head of School of Health and Population Sciences, University of Birmingham Medical School
Dr Celia Taylor	Senior Lecturer in Medical Education, University of Birmingham Medical School
Dr Martin Wilkinson	Dean: General Practitioner Education, Health Education West Midlands
Dr June Jones	Senior Lecturer in Biomedical Ethics, University of Birmingham Medical School
Dr Jamie Coleman	Senior Lecturer in Clinical Pharmacology, University of Birmingham Medical School
Dr Andrew Whitehouse	Foundation Programme Director, Health Education West Midlands
Dr Helen Goodyear	Associate Dean for Medical Careers, Health Education West Midlands
Professor Jim Parle	Professor of Primary Care, University of Birmingham Medical School

Research Team

JAMES ARTHUR
PRINCIPAL INVESTIGATOR

Professor James Arthur, Director of the Jubilee Centre for Character and Virtues, is the Head of the School of Education and Professor of Education. He has written extensively on the relationship between theory and practice in education, particularly the links between communitarianism, social virtues, citizenship, religion and education. A leading expert in the field of character and values, James is also Editor of the *British Journal of Educational Studies* and Director of CitizED, an organisation in higher education promoting citizenship.

KRISTJÁN KRISTJÁNSSON

Professor Kristján Kristjánsson is a Deputy Director in the Jubilee Centre for Character and Virtues, and Professor of Character Education and Virtue Ethics. He is also an editorial board member of the *Journal of Moral Education.* Kristján leads and oversees all the research activities in the Centre and has written widely on moral education, with his main area of interest being research in character and virtues at the intersection between moral philosophy, moral psychology and moral education.

HYWEL THOMAS
PRINCIPAL INVESTIGATOR

Professor Hywel Thomas is Professor of the Economics of Education in the School of Education. His principal areas of research are the application of ideas from economics to education and research on the economics of professional learning in the health sector, as well as other professions. This has contributed to a diversity of projects, including work on the finance of schools and colleges, the career paths of graduates, the management of resources and the deployment of staff in educational institutions.

BEN KOTZEE

Dr Ben Kotzee is a Lecturer in the Jubilee Centre for Character and Virtues. He works on topics in the philosophy of education and focuses on the nature and promotion of moral and intellectual character development. He has an active interest in professional education and the nature and acquisition of professional expertise. Ben is assistant editor of the *Journal of Philosophy of Education.*

AGNIESZKA IGNATOWICZ

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TIAN QIU

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Acknowledgements

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ISBN: 978-0-7044-2848-5