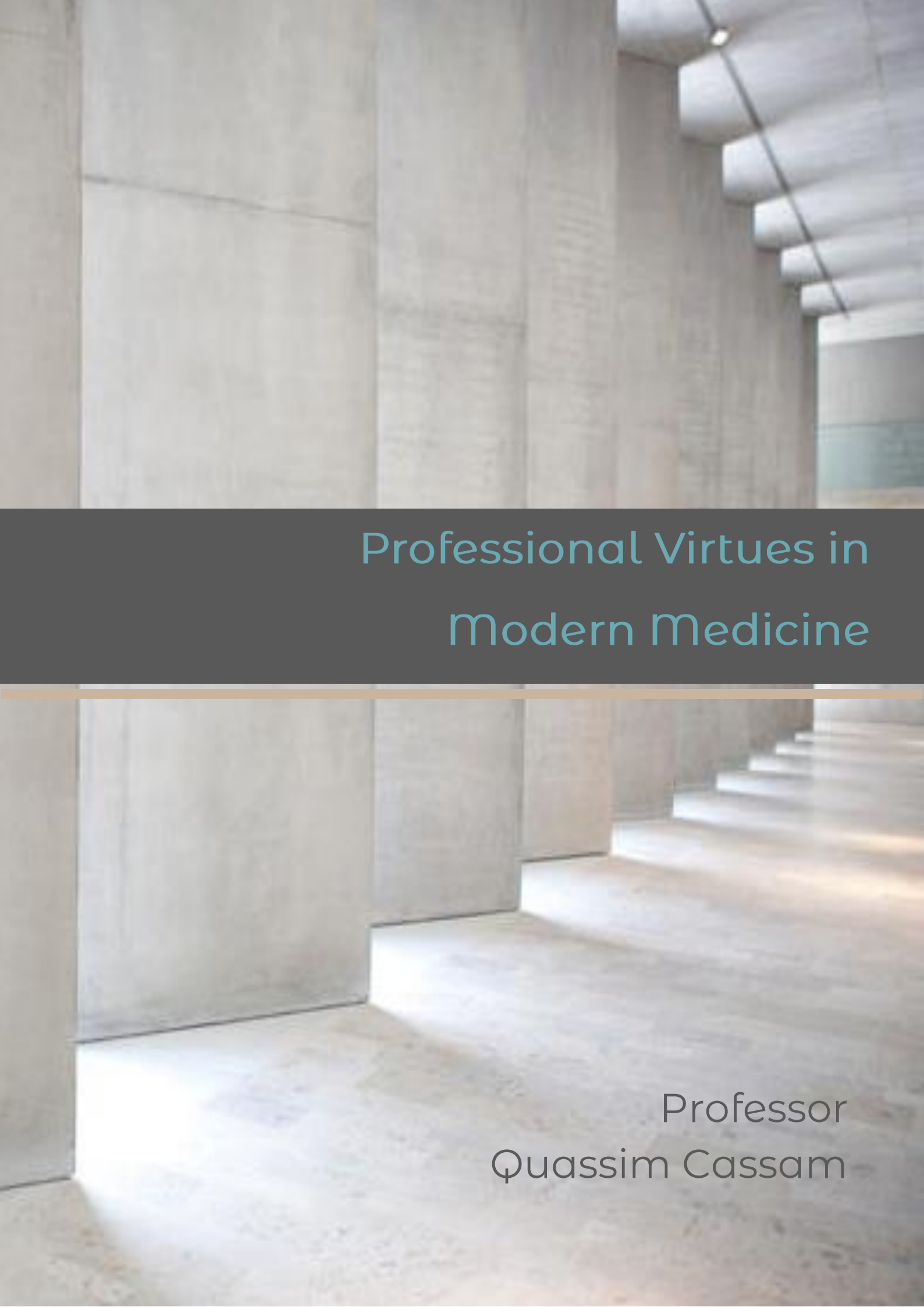

Professional Virtues in Modern Medicine

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Professional Virtues in Modern Medicine

A toolkit for GPs and other health professionals

- What are the qualities of a good doctor?
- How do we know what these qualities are and what can we do to cultivate them?

The aim of this e-book is not only to suggest possible answers to these questions but to provide doctors and other health professionals with the philosophical tools to think about these issues for themselves, to reflect on their own practice, and arrive at their own conclusions.

This e-book focuses on general practice, on what it takes to deliver excellent whole person care. However, all health professionals should find something useful here.

This e-book was put together by Professor Quassim Cassam of the University of Warwick.

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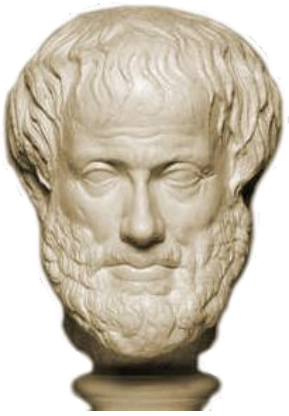
Professional Virtues, Institutional Vices

Starting with Aristotle



Why talk about 'virtues' at all? The philosopher Aristotle saw virtues as excellences and his views about virtue remain hugely influential today. They also provide a highly effective means to organize one's thinking about professional virtues, even though this is not a subject that directly interested Aristotle. The virtues he was interested in were moral virtues like courage.

For Aristotle, a person's moral virtues are their moral excellences, the personal qualities that make them morally good or excellent people. By extension, their professional virtues are their professional excellences. They are the personal qualities that make them good or excellent members of their profession. How do professional virtues do that? Each profession or professional role has its own virtues. The professional virtues of medicine are those personal qualities that make it possible for doctors and other health professionals to fulfil their professional role. Professional virtues can be, but needn't be, moral virtues.

Aristotle contrasts virtues with vices. If virtues are excellences then vices are flaws or defects. Moral vices are moral defects and professional vices are personal factors that hinder or obstruct the fulfilling of one's professional role. Some vices, such as lack of compassion, are both moral and professional. Without compassion it is hard to be a good person or a good doctor.

The Institutional Context

Professionals don't work in isolation. Any account of the professional virtues and vices of modern medicine also needs to take account of the institutional context. This context can help or hinder the cultivation and practice of virtue. It isn't all about the individual, and reflecting on the virtues of a good doctor can also help us to see the strengths and weaknesses of particular ways of organizing the delivery of health care at the institutional level.

There are many institutional barriers to being a virtuous professional. The target culture and excessive bureaucratization are two obvious examples of what might be called institutional rather than personal professional vices of modern medicine. Overcoming institutional vices requires institutional change. A good way to think about the necessary institutional changes is to think about the specific ways that current arrangements are at odds with the cultivation and exercise of professional virtues.

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Let's Be Realistic

It's easy to talk about the virtues of a good doctor. However, any account of professional virtues needs to take account of the real-world conditions in which professionals operate. As Christopher Dowrick notes:

> '*[E]ffective person-centred care is becoming increasingly difficult to practice. The pressures on primary care to comply with a plethora of clinical guidelines and public health agendas, however well-intentioned they may be, all too often conflict with the person-oriented approach which is the hallmark of good general practice encounters*'

Aside from such conflicts there are also more mundane but nonetheless hugely important human factors to consider. There are limits to what it is possible to achieve in a 10-minute consultation, especially if one is already tired and overworked. An account of professional virtues in modern medicine needs to take account of such factors. Indeed, the professional virtues of modern medicine will include the personal qualities that medical practitioners need to cope with the stresses and strains of their chosen profession. Resilience is one such virtue.

References and Further Reading

A good introduction to Aristotle's conception of virtue can be found in the Stanford Encyclopedia of Philosophy: https://plato.stanford.edu/entries/ethics-virtue/

The quotation from Christopher Dowrick is from his preface to this collection of essays: https://www.routledge.com/Person-centred-Primary-Care-Searching-for-the-Self/Dowrick/p/
All the essays in this volume are highly recommended.

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What is a Professional Virtue?

Getting Started

Consider a humble everyday object like a knife. What makes a knife a 'good' knife? That depends on the function of a knife. If the primary function of a knife is to cut, then a good knife is one that is sharp enough to cut well. Of course, there are many other things one might look for in a good knife: how pleasing it is to look at, how easy to grip, and so on, but if cutting is the primary function of a knife then sharpness is its primary virtue or excellence. In the words of the philosopher Philippa Foot, where a thing has a function, the primary criterion for the goodness of that thing will be '*that it fulfils its function well*'.

Perhaps, a knife can be too sharp, that is, so sharp that it endangers its user. So, an excellent knife will be one that is sharp enough to cut well but not so sharp as to be dangerous. Just the right degree of sharpness is, as one might call it, a knifely virtue. For Aristotle, a virtue is the mean between having too little of something and too much of it. In a knife, the right degree of sharpness is the mean between a deficiency (being too blunt to cut) and an excess (being too sharp to use safely).

Professional Virtues and Professional Roles

What does this example tell us about professional virtues? Doctors and other professionals don't have 'functions' in the way that things like knives have functions. Furthermore, virtues in the strict Aristotelian sense are personal qualities. Indeed, for Aristotle, virtues are not just personal qualities but traits of character. It's not clear that he is right about this but the account of the 'knifely' virtues is obviously going to have to be adapted if it is to apply to things that do not have functions.

What professionals have is not functions but roles, goals and challenges. This suggests a relatively straightforward way of thinking about professional virtues: the virtues of a given profession are those qualities that enable members of that profession to fulfil their professional role well, to achieve the goals of their profession, and to meet their professional challenges. As Peter Toon puts it, '*professionals must be equipped with the virtues they need to face the challenges of their professional role, which has important implications for professional education and training*'.

What this brings out is that identifying the professional virtues of medicine means identifying the distinctive roles, goals and challenges of the medical profession. This is not an easy task since the medical profession is not one thing. Health professionals do many different things. The professional virtues of a generalist might be different from those of a specialist, and the professional virtues of one type of specialist may well be different from those of another.

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Generalism is the focus of this toolkit. In the words of Sally and George Hull, '*the expert GP has acquired and manifests a distinctive set of virtues*'. The challenge is to identify these virtues by reflecting on the nature of medical generalism, and on the goals and challenges of the generalist as distinct from the specialist.

Approaching the subject in this way has one major advantage. Over the years, a great deal has been written about the medical virtues. Many lists of such virtues have been proposed, but what is not clear is the basis on which particular virtues are included or excluded. There is a distinct air of arbitrariness about the various lists that have been proposed, and no obvious basis for preferring one list of virtues to another. This is the fundamental problem to which a solution is needed.

This toolkit develops a solution to this problem. The basic idea of this toolkit is to reflect on the professional role of the medical generalist and then derive the generalist virtues from a reflective understanding of that professional role. Our understanding of the specific virtues of generalist medicine must be shaped by a proper understanding of the nature of generalism, of its goals and challenges. If we can identify the objectives of generalist medicine, it should then be relatively straightforward to identify the specific personal qualities that make it possible to attain those objectives.

References and Further Reading

The quotation from Philippa Foot is from '*Goodness and Choice*', a paper which appears in her book *Virtues and Vices* and other essays in moral philosophy:
https://global.oup.com/academic/product/virtues-and-vices-9780199252862?cc=gb&lang=en&

The quotation from Peter Toon is from his book *A Flourishing Practice?*
https://oapen.org/search?identifier=625890

Another interesting and useful book is *Virtue Ethics and Professional Roles* by Justin Oakley and Dean Cocking:
https://www.cambridge.org/core/books/virtue-ethics-and-professional-roles/

Also well worth reading is this paper by Preston Stovall on professional virtues in a different context: https://www.ncbi.nlm.nih.gov/pubmed/19915957

The quotation from Sally and George Hull is from their paper '*Recovering general practice from epistemic disadvantage*', which appears in this extremely useful book edited by Christopher Dowrick: https://www.routledge.com/Person-centred-Primary-Care-Searching-for-the-Self/Dowrick/p/

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Defining Medical Generalism

Why a Definition is Needed

The virtues of a given profession are those personal qualities that enable members of that profession to fulfil their professional role well, to achieve the goals of their profession, and to meet their professional challenges. If we can identify the professional role of the medical generalist then we should be able to arrive at an understanding of the professional virtues of medical generalism, the personal qualities required to be an excellent generalist. There are many different ways of identifying the role of the medical generalist but it would be sensible to begin by trying to come up with a working definition of medical generalism. In the UK, the best-known medical generalists are General Practitioners (GPs). What do GPs do? What is their expertise and how they differ from specialists? If we can answer these questions then we should also be able to develop a clearer understanding of the professional virtues of general practice.

Where to Start

The Royal College of General Practitioners defines medical generalism as:

> '*expertise in whole person medicine, which requires an approach to the delivery of health care that routinely applies a broad and holistic perspective to the patient's problems*' (MG, p. 3).

The Medical Schools Council suggests the following definition:

> '*Medical generalists are doctors who are prepared to deal with any problem presented to them, unrestricted by particular body systems, and including problems with psychological and social causes as well as physical causes. They take a holistic approach, mindful of the context of the local community. Medical generalism is therefore distinct from specialist care restricted to a particular body system or subset of medical practice, or restricted by virtue of having access to, or involvement in, providing particular types of interventions in particular settings*' (MSC, 1(a)).

These are just two examples of many attempts to define medical generalism. Although such definitions are undoubtedly helpful and cover many important points, it is hard to say everything that needs to be said in a brief definition. Such definitions need to be supplemented in various ways, and a promising way to do that is to look at a series of specific dimensions in relation to which the key distinguishing features of medical generalism can be specified.

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What are the relevant dimensions? To pin these down we might ask the following basic questions:

- What is the *professional role* of medical generalists? How does their professional role differ from that of the specialist?
- What are the distinctive *challenges* faced by medical generalists?
- What are the distinctive *goals or objectives* of the medical generalist?
- What is the distinctive *orientation* of the medical generalist? What is the focus of the medical generalist's attention?
- What are the medical generalist's distinctive *methods or ways of working*?
- What kinds of *knowledge or understanding* do medical generalists seek and rely on in their work? How is the generalist's understanding different from the specialist's understanding?
- What are the distinctive *values* of the medical generalist?

It's hard to give definitive answers to these questions. It's better to think of them as invitations to reflect on different aspects of medical generalism. What follows is one series of reflections, and an invitation to users of this site to engage in their own thinking about these difficult issues.

The Professional Role of the Generalist

The medical generalist's professional role is to a considerable extent determined by the institutional context in which he or she operates. In the UK context, GPs are usually the first point of medical contact for the patient, and their role includes assessing and arranging appropriate next steps for the large variety of conditions that are presented to them. This may or may not involve referral to a specialist. In the words of the Medical Schools Council, medical generalists optimize the use of resources by '*referring only those patients likely to need specialist help into the secondary care system*' (MSC, 1 (a)). This has been described as the generalist's 'gatekeeping' role.

In many cases the GPs are themselves able to give the appropriate medical advice and prescribe appropriate drugs. They may also decide that the problem they are confronted with is not a medical problem. In the words of one submission to the RCGP's Commission on Generalism, '*GPs are risk managers and recognize that not all symptomology requires investigation, referral or treatment but requires…. the allaying of fears and explanations of the problem*' (quoted in MG, p. 10). However, perhaps the most useful and comprehensive account of the professional role of the medical generalist is this one, from the Medical Schools Council's response to the RCGP's Commission on Generalism:

> '*General medical practitioners provide first contact and ongoing, continuous integrated care for a comprehensive range of problems to all members of the population for whom they are responsible. In well-developed primary care systems they undertake long term responsibility for a defined, registered list of patients, restricted only by geographical area, addressing both acute and chronic conditions and increasingly co-morbidity*' (MSC, 1 (a)).

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The Challenges of Medical Generalism

The challenges facing the medical generalist have been well described by Joanne Reeve. She notes that since GPs manage all aspects of a person's illness experience, the central challenge is '*dealing with the complexity of multiple pathology, or dynamic, changing complex illness*'(IM. p. 1). One conclusion that some have drawn from this is that generalism is about breadth, whereas specialism is about depth:

> '*What distinguishes generalism from specialism? The most obvious contrast is that where specialism is about depth, generalism is about breadth: the greater the depth of expertise in a branch of medicine, the more specialist the doctor; the greater the breadth of expertise, the more generalist. At the extreme, and to accentuate the distinction, this can be portrayed as a cultural divide*' (GPTC, 2.4).

This is not to say, however, that the generalist's knowledge is superficial, or that generalism is not a form of expertise in its own right. The expert generalist requires special skills to deal with the wide range of medical and other problems they encounter. Breadth is not incompatible with depth.

Furthermore, as Reeve notes, much of the generalist's time is spent '*dealing with "indistinct" illness – stress and distress, tiredness, pain' where 'no clear pathology or causal chain can be identified*' (IM, p. 1). The generalist deals with the individual patient, but clinical guidelines are derived from observation of populations. There is therefore always the challenge of '*applying knowledge about normal function and disease to this individual's illness*' (IM, p. 11). There is more below about the significance of this point in the section on the orientation of medical generalism.

The Goals of Medical Generalism

Patients typically visit their GPs when they feel unwell or are concerned about their health. Feeling unwell, or having the sense that there is something wrong with one's bodily self, is a problem for patients not just because of the associated pain or discomfort. It also gets in the way of daily living. In some cases, the person seeking the help of the medical generalist feels unwell because of an underlying disease or clear pathology. The distinction between illness and disease has been explained as follows by Iona Heath:

> '*Illness is a perception of something being wrong, a sense of unease in the functioning of the body or mind; disease is a theoretical construct, a unit in the taxonomy of scientific medicine, which offers both the benefits and the risks of that endeavor. GPs see much more illness than disease but for specialists, the opposite is true*' (DWF, p. 578).

Where a disease requires specialist treatment the goal of the medical generalist is to establish that this is the case and refer to patient to an appropriate specialist, while providing any appropriate advice and support. With illness, especially indistinct illness, treatment might not be a realistic objective. Many of a medical generalist's patients live with illness and pain. These

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patients face the challenge of coping with their condition and living their lives. In these cases, Reeve notes, the medical generalist's objective is to '*support individuals in their efforts to maintain continuity of daily life*' (IM, p. 8). Supporting individuals in this way means supporting them in their efforts to cope with their condition. There are many different ways in which medical generalists can do this but the key point is that the GP supports the individual in what Reeve describes as '*the dynamic process of living life*' (IM, p. 10).

Peter Toon argues that '*health care exists to promote good health in the same way as architecture exists to produce good buildings*' (AFP, p. 39). Specifically, health care contributes to human flourishing in at least three different ways: it relieves suffering and cures disease, it prevents illness and disease, and it helps patients to make sense of what is happening to them. The third of these objectives is an important purpose of health care, and one in relation to which the medical generalist plays a key role. To quote Toon again:

> '*Many people go to their GP not principally because they want to change what is happening to them but because they want to understand it. Is it serious or is it trivial? Will it get better, and how quickly? What impact will it have on their work, their family life, their social and sporting activities? Answering questions like these is an important aspect of health care for which clinicians are ill-equipped by their basic education. It is part of the third aspect of health care, the interpretive function – giving prognostic information and helping patients understand their illness*' (AFP, p. 45).

It is debatable whether patients with treatable conditions do not go to their GP principally because they want to change what is happening to them. Nevertheless, sense-making is an important objective of health care generally and medical generalism in particular. The human desire for self-understanding includes the desire to understand their own bodies, especially during periods of ill health, and it is an important insight that many patients visit their GPs for self-understanding.

The Orientation of Medical Generalism

It follows from what has been said so far that the medical generalist is illness-focused rather than disease-centred. In addition, most accounts agree that medical generalism has what the RCGP describes as a '*person-focused orientation*'. In other words, '*generalists are professionals who are committed to you as a person*' (MG, p. 3). In this context, 'person' means whole person, hence the popular notion that the medical generalist delivers 'whole-person' care. But what exactly is whole-person care? Isn't it also a type a care that many specialists provide? The whole person as opposed to what? To answer these questions, it would be helpful to know what is meant by 'person'. There is a separate page devoted to this. But even without going into this in detail at this point, there is still quite a bit that can be said about the 'whole person' orientation of medical generalism.

In the literature on medical generalism, one popular way of explaining its focus on the person is by means of a series of contrasts: one is between the person and the illness. The medical generalist, it is said, must have '*an overriding interest in the person rather than the illness*' (GPTC, 2.3). A different contrast is between the person and the disease. The medical generalist, it is

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suggested, focuses on the person rather than the disease conceived at the level of organs and tissues. It is the former rather than the latter that is the object matter of generalist medicine. Yet, despite their popularity, the significance of these contrasts is not entirely clear. A sceptical response to the person/ illness contrast might be to point out that it is entirely appropriate, when dealing with a patient who is feeling unwell, to focus on their illness. How can it be right to have an overriding interest in the patient rather than their illness when it is only because of their illness that the patient has sought out their GP? The same goes for the patient/ disease contrast. As has been noted, GPs see much more illness than disease. However, when the medical generalist is confronted by evidence of disease it would be perverse not to focus on the disease, especially if it is potentially serious.

Perhaps, in that case, the real point of insisting that the medical generalist should concentrate on the patient rather than the illness or disease is a different one. It is possible to interpret it as making a contextual point: '*the generalist sees health and ill-health in the context of people's wider lives*' (GPTC, 2.9), that is, '*in the context of his or her family and wider social environment*' (MG, p. 8). Yet the relevance of family and wider social environment varies from patient to patient and condition to condition. Such factors might be of great relevance for patients with severe health problems or disabilities, but much less relevant to a generalist's response to minor ailments. Dealing with a sore throat does not, on the face of it, require the GP to engage with the context of people's wider lives. What remains true, however, is that the medical generalist must be willing and able to see health and ill-health in the context of people's wider lives where this perspective is relevant and appropriate.

Other aspects of generalist medicine can be understood in the same spirit. In her article on the 'Subjectivity of patients and doctors', Iona Heath emphasizes the individuality and the subjectivity of patients and doctors. She writes that '*the task of the clinician is to engage with the details of the fears, hopes, needs, and values of each individual patient*' and that '*within any consultation, the moral obligation of the professional is to do his or her best for that particular real living person*' (SPD, p. 84). She emphasizes the '*fine-grained particularity of each unique human self*' (SPD, p. 85) and quotes Tolstoy in support of the notion that '*no two individuals ever experience illness or disease in the same way*' (DWF, p. 276).

Again, one might wonder whether individuality and subjectivity are relevant to the same extent with all patients. There are, on the face of it, some ailments which most individuals experience in, if not exactly the same way, then in ways that aren't significantly different. One person's subjective experience of running a high temperature is, presumably, not hugely different from another person's subjective experience of running the same temperature, even if the causes are not the same. Again, the details of an individual's hopes, needs and fears may be highly relevant when it comes to some medical decisions but not others. Perhaps, therefore, it would be more accurate to say not that the medical generalist must always engage with the patient's subjectivity but must always be prepared to do so where such engagement is helpful and relevant.

In engaging, or being prepared to engage, with a patient's subjective reality and fine-grained particularity the expert medical generalist does not lose sight of the underlying physical or physiological story. Whole person medicine is not a matter of focusing on the patient rather than their illness but of having two perspectives on one and the same patient, and being able

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to move seamlessly from one to the other as the need arises. This is what Heath is getting at in the following passage:

> '*Within every clinical consultation both professional and patient oscillate between perceiving the human body as an object and as a subject. When the body is perceived as an object, the gaze of biomedical science sees only what the particular patient has in common with other patients. On the other hand, when we seek to understand the body as a subject, we speak about what is unique about this person – their life context, its story and the meanings that adhere to both*' (SPD, p. 92).

When the body feels pain or fear it is the body as subject. The body as tissues and organs and other physiological components is the body as object, as a mechanical system. The body is both a subject and an object or, as the philosopher Merleau-Ponty puts it, a 'subject-object'. This means that the essence of medical generalism is to be able engage with both the subjective and the objective dimension of the body and the person whose body it is. Which, if either, of the two dimensions is prioritized in an individual case will depend on the specifics of the case.

The Medical Generalist's Way of Working

In his preface to *Person-centred Primary Care*, Dowrick notes that '*primary health care professionals, including general practitioners and family doctors, are encouraged to work collaboratively with their patients, fostering shared decision-making and promoting self-management*' (PCPC, p. vii). The implication of this approach is that medical generalists are, or should be, engaged in a dialogue with their patients. The care provided by the medical generalist is continuous rather than episodic and is responsive to the patient's own experience and understanding of their condition. Unlike specialists, GPs don't discharge their patients and they may see the same patients over a long period of time. Medical generalists may get to know their patients as people, and must work with them in an effort to find solutions to their problems.

According to Joanne Reeve, '*general practice is about interpretation of illness, not identification of disease; knowledge is not uncovered ('mined') but constructed as the clinician and patient "travel" together, creating a joint account of illness that meets the needs of both*' (IM, p. 7). The key idea here is that of co-construction. Rather than the patient being a passive recipient of medical advice from the medical generalist he or she is actively involved in interpreting their condition and fixing on an appropriate medical or non-medical response.

As Toon notes, '*this view of health care as a collaborative practice involving both patients and professionals has implications for how patients and professionals relate to each other. It casts professionals and patients as collaborators in a struggle against suffering and incapacity: as "co-producers" of health*' (AFP, p. 34).

One concern about the collaborative approach is that it privileges the confident, the articulate and the educated. Some patients may be too diffident to be actively involved in creating a joint account of their illness, or might take the view that it is for the expert GP to do the interpreting for them. A challenge for the interpretive model is to explain how it applies in such cases.

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Knowledge and Understanding in Medical Generalism

Is there such a thing as 'generalist knowledge' or 'generalist understanding'? If so, what distinguishes it from other kinds of medical or non-medical knowledge? On one interpretation, generalist knowledge is a particular type of knowledge or understanding that the expert generalist has of his or her patients. We can call this generalist patient knowledge. On the other hand, there is also the generalist's medical knowledge, the biotechnical knowledge that expert generalists rely on in diagnosing, treating and advising their patients. We can call this generalist medical knowledge. Giving this distinction, a natural way to work out what is so special about medical generalism is to work out what is so special and distinctive about generalist patient knowledge and generalist medical knowledge.

Starting with generalist patient knowledge, it has been suggested that the medical generalist's special way of knowing his or her patients includes having a longitudinal relationship with them over many years, knowing their patients' family and community, knowing the context of their patients' lives, and knowing '*the nature of their problems in depth*' (MG, p. 12). The RCGP concludes that the ability to form appropriate, strong interpersonal bonds with patients is therefore '*an increasingly important aspect of the role of the medical generalist within the wider health system, especially in the context of the need to develop an approach to health care that is more person centred and focused increasingly on prevention*' (MG, p. 13).

Related to the notion that medical generalists 'know' their patients in a special way is the idea that their understanding of their patients isn't purely 'biomedical'. Rather, their biomedical understanding must be coordinated with, and supplemented by, what Heath calls '*biographical understanding*' (DWF, p. 582). This is the basis on which Hjörleifsson and Lea complain about the fact that too often '*biological approaches trump biographical interpretations of patients' problems, rendering the latter invisible or their relevance inconceivable, leading to harmful overdiagnosis and medicalization of human suffering*' (MIGP, p. 28).

Several questions now arise: what is the biomedical understanding of patients or, as it is sometimes called, the 'biomedical model'? What exactly is 'biographical understanding', and why is this type of understanding indispensable for medical generalism? Once these questions about generalist patient knowledge have been answered attention can then turn to generalist medical knowledge.

A classic account of the biomedical model is this one given by George L. Engel in 1977:

> '*[T]he dominant model of disease today is biomedical, with molecular biology its base scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioral dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioral aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes*' (quoted in MIGM, p. 25).

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Thus, the biomedical model conceives of patients primarily as biological rather than social organisms and their illnesses as fully accountable at the biological or biochemical level.

Biographical understanding is harder to define. According to Iona Heath, the first and second person pronouns, I and you, are '*the stuff of biography, of human relationships and of clinical medicine, rather than the impersonal third person of he, she, or it, which is the stuff of biology and biomedical science*' (SPD, p. 85). Yet biographies are usually written from a third person perspective, so it isn't obviously correct to equate biographical understanding with the ability to relate to other people second personally rather than third personally. Equally, it is possible to address another person as 'you' without having the slightest interest in their life story or any biographical understanding of them.

This points to a much more straightforward understanding of biographical understanding: biographical understanding of patients means understanding them in the context of their lives and personal histories. It means understanding and engaging with their fears, hopes, needs, and values. Above all, it means attending to what Heath calls their '*subjective reality*' (SPD, p. 88). To think of another person's subjective reality is to think of them as not simply as biological organisms but irreducibly as subjects of experience, with their unique perspective on the world and experience of illness.

Why do medical generalists have to have a biographical understanding of their patients? Heath's answer to this question is that biographical understanding is necessary because '*individual biography affects biology*' (SPD, p. 94). Negative psychological states such as chronic stress can 'undermine the healthy functioning of the human body', and an understanding of a person's biography can help the generalist to understand some illnesses by understanding how some aspects of their patients' lives might have contributed to their ill health. No doubt there are conditions that can be diagnosed, understood and treated with little or no biographical understanding but it is important that the generalist can bring biographical knowledge to bear where appropriate.

Another consideration is that many sources of physical discomfort to patients are poorly understood in biomedical terms. For example, conditions like burning mouth syndrome (BMS), for which there is no effective treatment, might nevertheless cause those who suffer from it considerable discomfort and distress. Since stress and anxiety are among the known risk factors for BMS, a generalist's biographical understanding of a sufferer might be more useful in practice than a biomedical perspective. In most cases, however, both perspectives are necessary and the challenge is to integrate the biomedical and the biographical.

Among the distinctive features of generalist medical knowledge is what Reeve calls its '*epistemological uncertainty*', the uncertainty that '*comes in seeking to apply "certain" knowledge derived from the study of populations to understand this individual patient*' (IM, p. 2). General practice is not an exact science, especially when dealing with patients with indistinct conditions, multiple morbidities and chronic illnesses. As the RCGP notes, most patients with complex

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multisystem problems '*need generalists to care for them, so that all issues can be addressed and the pros and cons of treating each problem fully understood*' (MG, p. 17).

This is the type of scenario that has led some to conclude that generalists rely less on biomedical evidence than specialists and more on social-science based evidence. According to one formulation, '*whereas the specialist relies heavily on scientific evidence to arrive at a precise explanation of an illness within a limited range of possibilities, the generalist (especially the GP) takes a far broader approach to arrive at one or more probabilities and decide whether or not action is needed*' (GPTC, 2.5).

These are among the considerations that have led some accounts of medical generalism to highlight its breadth while downplaying its depth. It has even been suggested that among the core values of medical generalism is '*a willingness to eschew opportunities to develop the deepest knowledge of particular problems required to be a specialist practitioner, and to avoid sub-specialisation*' (MSC, 2). Yet, as noted above, breadth is not incompatible with depth and it is arguable that what distinguishes the generalist from the specialist is not depth of knowledge per se but the kinds of knowledge they rely on and seek.

The Values of Medical Generalism

One's values are one's fundamental guiding principles. They are usually an expression of one's ethical outlook, and their function is to guide one's judgements, decisions and actions. For example, one might rule out a certain course of action because it conflicts with one's values. Other courses of action might strike one as obligatory on account of one's values.

The fundamental value of medical generalism, and indeed of all varieties of medicine, is the principle that every patient, regardless of age, sex, class or race, is worthy of equal concern and respect on account of their shared humanity. This guiding principle is derived from the work of the great 18th century philosopher Immanuel Kant, who insisted that each and every person possesses a dignity or absolute inner worth on account of which they are worthy of respect. Such respect includes respect for their autonomy, and this has important practical implications for person-centred medicine. One implication is that medical generalists must make every effort to respect their patients' choices and preferences. Different things are important to different people, and what might be right for one patient might not be right for another. To put it another way, respect for persons requires taking account of what Heath describes as the '*fine-grained particularity of each unique human self*' (SPD, p. 85).

This core generalist value has its limits, however. For example, respect for the fine-grained particularity of each unique human self does not require the medical generalist to defer to a patient's desire take harmful or addictive drugs even if the patient insists that not being given access to such drugs is a violation of their autonomy. Nor is the medical generalist required to help a patient to die even if this is what the patient genuinely desires. On a Kantian view, helping a person to die is itself incompatible with the principle of respect for persons, and so can't be required by it. These are among the difficult ethical issues that the generalist faces. What they

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illustrate is the need for the generalist to be equipped not just with a set of guiding principles but also with the philosophical tools needed to work out how they apply in a given case.

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Ten Generalist Virtues (and how to cultivate them)

Generalist Virtues

According to the Michigan State University College of Human Medicine (MSU/ CHM), the three key virtues of the 'virtuous professional' are courage, humility and mercy. Courage includes the readiness and ability to do what is ethically best. Humility 'refers to a deep appreciation of the limits of our knowledge, skills or abilities to make the right decision'. Finally, mercy 'refers to our disposition to meet the needs of others out of empathy'. These three virtues, which are also described as 'ideals', are said to support 'the highest exercise of our professional responsibilities'. MSU/CHM lists six professional responsibilities: competence, honesty, compassion, respect for others, professional responsibility and social responsibility:
(http://humanmedicine.msu.edu/Medical_Education/Assets/The-Virtuous-Professional_a11y.pdf).

Although there is undoubtedly an element of arbitrariness in the division of virtues and responsibilities, nobody could argue with the suggestion that courage, humility and mercy are generalist virtues. What is less obvious is that they are specifically generalist virtues. Rather, they are virtues that all professionals and perhaps all human beings should have. They are not tied to, or preconditions of, the medical generalism per se. The virtues of medical generalism per se are those personal qualities that enable medical generalists to fulfil their professional role, achieve the goals of medical generalism and meet its professional challenges. Having already identified these roles, goals and challenges, as well as medical generalism's orientation, ways of working and distinctive modes of knowledge, (see Defining Medical Generalism), it should now be possible to list its enabling virtues.

1. Attentiveness

The status of attentiveness as a generalist virtue is a reflection of generalism's orientation and the biographical understanding it seeks. Medical generalism's whole person orientation means that it must be serious about engaging with the individuality and subjectivity of patients, as well as the context of their family and social environment. Engaging with these things requires a high degree of attentiveness on the part of the generalist, a willingness to attend to individual

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narratives and the subjective reality of each patient. Engaging with each patient as an individual in his or her own right makes considerable emotional and intellectual demands on the medical generalist, and one thing it demands is the generalist's undivided attention.

The indispensability of the virtue of attentiveness is also implied by the core generalist value of respect for persons. As Iona Heath puts it, 'if healthcare systems are to treat people as ends in themselves and thereby recover the self and respect the subjectivity of both patients and professionals, the primary requirement is that we should pay genuine attention to each other' (p. 85). If this is right then attentiveness is a moral as well as practical requirement on the medical generalist.

2. Curiosity

Another implication of the distinctive orientation of medical generalism is that it requires the generalist to have the virtue of curiosity. As the philosopher Neil Manson has noted, curiosity can be a vice when it is excessive or inappropriately targeted. There are some things about other people, perhaps other than one's nearest and dearest, that it is better not to know and better not to want to know. Respect for another person's privacy requires at least a degree of incuriosity. Nevertheless, curiosity is a generalist virtue when it is not excessive and properly exercised. How is it possible to understand a patient's fears, hopes, needs and values if one doesn't know what they are? And how is it possible to come to know about these things unless one is curious enough to find out?

The status of curiosity as a generalist virtue flows in part from the role of biographical understanding in general practice. The conscientious medical generalist must seek least a degree of biographical understanding of his or her patients (see Defining Medical Generalism). The desire for such understanding is a form of curiosity. However, an effective generalists' curiosity is not confined to their patients. There is also the need for a more abstract form of intellectual curiosity about biomedical science. There is the need to 'keep up' with the latest research, to the extent that it is relevant to general practice. An intellectually curious medical generalist is more likely to keep up than one who is incurious or disinterested.

3. Detachment

Just as it is possible to be too curious about a patient, it is possible for a medical generalist to become too emotionally involved and too deeply affected by their pain or distress. Such excessive involvement or concern can impair one's medical judgment and be destructive of the medical generalist's own well-being. This is why the right degree of detachment – not too much

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or too little – is a genuine generalist virtue. Detachment is the golden mean between casual indifference and excessive involvement. It is closely related to objectivity.

The appropriate degree of detachment is compatible with genuine concern for one's patients but does not impair one's judgement or impose excessive emotional demands on the generalist. It is a form of emotional self-care that makes generalists more resilient and less prone to burn-out. In order to care for their patients, generalists must care for themselves. Anything that contributes to the generalist's professional self-care has a reasonable claim to be regarded as a generalist virtue.

4. Empathy

Empathy is often described as a generalist virtue and part of what the RCGP calls '*the ethos of medical generalism*'. On the other hand, empathy also has its critics. In his book *Against Empathy*, psychologist Paul Bloom distinguishes between empathy and compassion and argues that '*when it comes to certain interpersonal relationships, such as between doctor and patient, compassion is better than empathy*' (pp. 50-51).

What is empathy? Writing in the 18th century, the philosopher and economist Adam Smith represented empathy – which he called '*sympathy*' – as the means by which we are able to know what other people are feeling. Since we can't experience other people's feeling directly, we put themselves in their shoes and imagine what we would feel in the same situation. According to Smith, this is the '*source of our fellow-felling for the misery of others*'.

The empathy that Smith describes is sometimes referred to as emotional empathy. Emotional empathy, as the label suggests, engages the emotions of the empathizer and so isn't a purely intellectual exercise. The contrast is with cognitive empathy. In cognitive empathy, one appreciates what another person is feeling but without mirroring their feelings. This is how Bloom describes the contrast: '*if your suffering makes me suffer, if I feel what you feel*' (p. 17), that's emotional empathy. If I understand that you are in pain without feeling it myself then this is cognitive empathy.

What kind of empathy is a virtue for the medical generalist? Some have argued that the whole person orientation of medical generalism means that the medical generalist must be willing and able to engage with the fears, hopes, needs and values of each individual patient. Engaging with another person's emotions means understanding what they are, and that requires cognitive empathy. Without empathy, other human beings become unreadable. It is also sometimes suggested that the professional role of medical generalists includes 'bearing witness' to the suffering of their patients. How can one witness suffering without recognizing it, and how can one do that without some cognitive empathy?

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Yet cognitive empathy is cold and bloodless. Merely understanding a patient's pain or suffering is not that same as engaging with it. Doesn't that require full-blooded emotional empathy? Isn't it necessary to feel their pain and not merely understand it? How can one really understand it if one doesn't feel it? This suggests that cognitive empathy isn't enough; doctors also need emotional empathy. However, critics of emotional empathy say that it is biased. As Bloom writes, '*it's far easier to empathize with those who are close to us, those who are similar to us, and those we see as more attractive or vulnerable and less scary*' (p. 31). What we all need, Bloom argues, is not emotional empathy but compassion. It isn't possible to empathize with the starving millions but it is possible to have compassion for them. Compassion is both more diffuse and less biased than empathy. In particular, it doesn't require one to 'mirror' others people's feelings.

There is also a more straightforward practical objection to classifying emotional empathy as a generalist virtue: it would be emotionally and psychologically disastrous to feel the pain or suffering of every patient. The generalist who tries to do that would burn out very quickly and, in all probability end, up as an emotional wreck. The same goes for other branches of medicine. Bloom quotes a surgeon saying that she would be incapacitated if, '*while listening to the grieving mother's raw and unbearable description of her son's body in the morgue*' (p. 142), she was to imagine her own son in his place. What doctors need is not this type of empathy but compassion, or empathy understood as compassion.

Yet there is something right about the concern that fully understanding another person's predicament requires some degree of emotional engagement with that person, even if it doesn't require one to mirror their feelings. In the words of the philosopher Olivia Bailey:

> '*A rough and ready way of thinking of about emotions' role in empathy is to conceive of the empathizer as encountering the other's situation through an appropriate emotional lens. When we try to empathetically imagine how things are for a recent widower, for instance, we attempt to look at his situation through the lens of grief*' (p. 144).

Looking through the recent widower's situation '*through an appropriate emotional lens*' doesn't require one to be grief-stricken in anything like the way that the widower is grief-stricken. On the other hand, it isn't mere compassion or cognitive empathy. Empathy in Bailey's sense '*is not bloodless or coldly cognitive*' (p. 144) and is, at least to this extent, a form of emotional empathy. It is this type of moderate emotional empathy that is required to really engage with and properly understand another person's feelings. It follows that moderate emotional empathy, combined with compassion, is a generalist virtue.

There is an obvious problem with regarding both emotional empathy and detachment as generalist virtues. Detachment requires generalists to maintain an emotional distance from their

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patients that seems incompatible with emotional empathy. This tension is genuine and not easily resolved. The medical generalist must be willing and able to look at every patient's situation through the appropriate emotional lens, while also maintaining enough emotional distance not to be emotionally incapacitated or lose their objectivity. This is the point of the idea that the empathy that is a generalist virtue is moderate emotional empathy. As with all virtues, it is possible to have too much or too little of a good thing and that applies to empathy as much as to anything else. Moderate empathy is compatible with a degree of detachment but isn't bloodless or coldly cognitive. It still places considerable demands on the generalist, and that is why the practice of generalism also depends on another professional virtue: resilience (see below).

5. Humility

According to the philosopher Alessandra Tanesini, humility is 'concerned with human limitations in general and one's own limitations in particular'. It is not just a matter of recognising one's limitations but of owning them, of taking them to heart. Intellectual humility is concerned with one's intellectual limitations while epistemic humility focuses on limitations in one's knowledge and ability to know. This is how the philosopher José Medina describes the benefits of humility:

> '*Having a humble and self-questioning attitude toward one's cognitive repertoire can lead to many cognitive achievements and advantages: qualifying one's beliefs and making finer-grained discriminations; identify one's cognitive gaps and what it would take to fill them; being able to formulate questions and doubts for oneself and others; and so on*' (p. 43).

Understood in this way, humility is a human virtue: it contributes in obvious ways to human flourishing and, in particular, to human intellectual flourishing. Is there any reason to regard humility specifically as a generalist virtue? Why do so many accounts of the medical virtues, such as the one put forward by the Michigan State University College of Human Medicine, take it for granted that humility is not just a human virtue but a professional virtue?

The rationale for highlighting the importance of humility in general practice is straightforward. It is one thing to insist that the task of the clinician is, as Iona Heath puts it, to '*engage with the details of the fears, hopes, needs, and values of each individual patient*' (p. 84) but there are limits in the generalist's ability to do this. It isn't just that generalists have limited time and energy to get to know their patients but that knowing other people and their problems is inherently difficult. Medical generalists who seek a biographical understanding of their patients would be well advised to recognize that this type of understanding is not always possible. Patients, like human beings generally, vary enormously in how easy or difficult they are to read, and the recognition of this obvious fact by the medical generalist is a form of professional humility.

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Another important form of professional humility pertains to the biomedical rather than biographical component of generalist medicine. It involves recognising the limitations of biomedical understanding and the inherent uncertainty of medical knowledge. General practice is not an exact science, especially in relation to patients with indistinct conditions, multiple morbidities and chronic illnesses. The limitations of medicine are well understood by most generalists and their understanding of these limitations is a form of professional humility. Professional humility matters because it keeps the expectations of doctors and patients in check and might also play a role in combatting overdiagnosis and what has been described as the '*medicalization of human suffering*' (see Defining Medical Generalism, section 8).

6. Lucidity

It has been suggested by Peter Toon that many people go to their GPs not principally because they want to change what is happening to them but because they want to understand it (see Defining Medical Generalism, section 5). This is the interpretive function of generalist medicine: giving patients prognostic information and helping them to understand their illness.

In order to do this effectively, medical generalists need to be excellent communicators. In particular, they need to be lucid. Lucidity pertains to speech and to thought. A lucid speaker is one who speaks clearly, in a manner that is easy to follow but without any sacrifice in accuracy. A lucid thinker is one who thinks clearly. Being a lucid thinker makes it easier to be a lucid speaker, and both forms of lucidity are generalist virtues: medical generalists need to be lucid if they are to communicate effectively with their patients and help them to understand what is happening to them.

7. Resilience

The indispensability of resilience has already come up in relation to empathy. The emotional demands of generalist medicine are difficult to exaggerate. Among the virtues of generalist medicine are those that contribute to generalist self-care. A way to reduce the emotional burdens of generalist medicine is to keep one's emotional distance from one's work and one's patients. It is possible to cultivate the virtue of detachment as a way of coping with the stresses of generalist medicine but there are limits to how detached the generalist can be or should be. It is because the generalist cannot afford to be too detached and must be capable of at least moderate emotional empathy that resilience is required. The greater the openness to stressful emotions, the greater the need for resilience.

The American Psychological Association defines resilience as 'the process of adapting well in

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the face of adversity, trauma, tragedy, threats, or significant sources of stress' (https://www.apa.org/helpcenter/road-resilience). It is the ability to bounce back from difficult experience and recover one's equilibrium. A resilient person is not unfeeling or indifferent. An unfeeling person has no need for resilience since their insensitivity is sufficient protection from distress. The need for resilience only arises if one is not indifferent, if one can genuinely relate to the suffering of others. To the extent that medical generalists need to be able to relate to the suffering of their patients they need to be resilient.

8. Self-Trust

Self-trust is trust in one's own knowledge, abilities and judgements. Self-trust is closely related to self-confidence. Without the appropriate degree of self-trust and self-confidence it is difficult for any professional to function effectively. Self-trust is even more important in medical decision-making. In order to diagnose one's patients it is essential that one trusts oneself to make an accurate diagnosis. The alternative is intellectual paralysis.

Knowledge requires a degree of confidence. If one knows that something is the case – that a patient has a chest infection, for example – one must be reasonably confident that it is the case. To be reasonably confident one must trust oneself to know, and trusting oneself to know is a basic form of self-trust. It follows that lack of self-trust is a threat to one's knowledge. There is more on the links between knowledge, self-confidence and self-trust in this TEDX lecture: https://www.youtube.com/watch?v=h-eQ2bR1HFk.

To say that one must trust oneself is to not say that one must trust oneself and have confidence in one's judgement regardless of the evidence of one's actual level competence. Self-trust needs to be earned and properly calibrated. It isn't justified unless one is in fact a competent judge. The generalists' degree of self-trust can and should vary according to career stage. It is appropriate that the self-trust of a newly qualified generalist is lower than that of an experienced colleague. Even in the case of the experienced medical generalist, self-trust needs to be combined with humility. It is a question of balance. The virtuous professional is neither lacking in self-trust nor excessively self-confident. Human fallibility, including one's own fallibility, must never be ignored.

9. Situational Judgement

The philosopher Ludwig Wittgenstein noted that for any given set of rules or guidelines there is always the question how they apply in a given case. Guidelines do not interpret themselves and it is always a matter of judgement whether and how they apply to an individual patient.

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The application of a rule or guideline involves moving from the abstract to the concrete and it is judgement that mediates this transition. This is how Sally and George Hull make the point:

> '*The skilled practice of generalist medicine may include knowing a set of abstracted rules and recommendations. But the work of a skilled GP could not be substituted by the mechanical application of a list of rules- however long. This is because it relies crucially on making situated judgements with the patient. Decisions are rooted in the immediacy of the patient context*' (p. 2).

As Wittgenstein also noted, this problem can't be solved by positing rules for the interpretation of rules because the rules for interpretation would also need to be interpreted. If one is to avoid an infinite regress of rules it is necessary for practitioners in any field to rely on their judgement, their sense of how a rule or guideline applies in the case at hand. Trisha Greenhalgh adds that:

> '*Situational judgement is particularly crucial in specialities characterised by a high degree of uncertainty, such as general practice. Time and again, evidence-based guideline proves ambiguous, incomplete, or throws light on a similar but not identical problem to the one that needs solving right now*'.

The difference between an excellent and less than excellent generalist is often a difference in the quality of their situational judgement. Experience and practice can improve a generalist's judgement, and excellent situational judgement is among the virtues that must be acquired and manifested by the excellent medical generalist.

10. Testimonial Justice

Testimony, in the philosophical sense, is the conveying of information by telling. If a patient tells a doctor that she has a sore elbow, and the doctor comes to know as a result that the patient has a sore elbow, then the doctor's knowledge is what philosophers call testimonial knowledge. Testimony, in this sense, is not confined to the courtroom. It happens '*whenever one person tells something to someone else*' (https://www.iep.utm.edu/ep-testi/).

There are cases in which, although the speaker is trying to share what she knows with someone else, she fails to do so because the hearer doesn't regard the speaker as credible. In these cases, the conveying of information by telling is stymied. Prejudice is among the many factors that can lead a hearer to discount a speaker's testimony. In such cases, the speaker is regarded as lacking in credibility on account of her race, gender, class, or some other aspect of her identity. Where the transmission of testimonial knowledge is stymied by the hearer's prejudices the speaker is a victim of what philosopher Miranda Fricker calls '*testimonial injustice*'. Testimonial injustice occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker's word.

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In one kind of case, the hearer doesn't take what the speaker says seriously because the speaker is a member of a marginalised social group.

In recent years, work by Havi Carel, Ian James Kidd and Sally and George Hull has explored the impact of testimonial injustice in healthcare. Kidd and Carel refer to complaints by patients that '*healthcare professionals do not listen to their concerns, or that their reportage about their medical condition is ignored or marginalised, or that they encounter substantial difficulties in their efforts to make themselves understood to the persons charged with their diagnosis and treatment*'. The reason, as Sally and George Hull note, is that:

> '*Chronically sick people are a group liable to be regarded as less credible by society in general, particularly when they are also elderly and/ or poor. Doctors are not immune to pervasive social prejudice, and those same prejudices in the doctor's mind and sensibility can very well lead them to discount or not take seriously the testimony of a patient in consultation*' (p. 11).

Kidd and Carel give many striking, and indeed shocking, examples of this form of testimonial injustice and its negative impacts on interactions between doctors and patients. Clearly, testimonial injustice potentially affects all branches of medicine. For example, it is at odds with the requirement that all doctors treat their patients with equal concern and respect, regardless of class, gender, race, sexual orientation, or health status. However, there are features of generalist medicine that make testimonial injustice especially problematic in that context. Generalism is a collaborative practice involving both patients and professionals, and it is difficult to see how it can be genuinely collaborative if the prejudices to which generalists are not immune lead them to regard some of their patients as lacking in credibility or as not to be taken seriously.

According to Fricker, '*the virtuous hearer neutralizes the impact of prejudice in her credibility judgements*' (p. 92). The virtue that such a hearer possesses and exercises is the virtue of testimonial justice, the capacity to neutralize prejudice in one's judgements of credibility. One way to exercise this virtue is to be prepared to think critically about the extent to which one's judgements of credibility are prejudiced and to make suitable adjustments to counteract the influence of prejudice. The virtue of testimonial justice facilitates mutually respectful collaborations between doctor and patient and, in this way, helps medical generalists to fulfil a key element of their professional role.

Self-Cultivation

According to Sally and George Hull, '*GPs are generalists whose medical expertise consists, to a significant extent, in the possession of a set of virtues*' (p. 3). What if an aspiring generalist doesn't already have all the necessary virtues? What can they do to acquire them? A virtue, the Hulls

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argue, is '*an acquired disposition of character, so a good generalist medical training should develop settled dispositions of character in a GP which enable them to make the right judgements in consultation with their patients*' (p.3).

How realistic is this? Like Aristotle, the Hulls assume that virtues are character traits. Again like Aristotle, they assume that character traits, understood as dispositions, can be acquired by training. Some philosophers have argued that, while our characters are relatively malleable during childhood, they are extremely hard to change or revise one they are fully formed in adulthood. If this is right then is it not completely unrealistic to expect medical schools, or anyone else, to help generalists to acquire and develop character virtues they don't already have? If character is destiny it follows that only individuals who already have the relevant traits are cut out for medical generalism.

There is an ongoing debate in philosophy and psychology about the malleability, or otherwise, of character traits. However, it is not necessary to think of virtues generally as character traits. Virtues like humility are not so much character traits as attitudes. A humble person has a particular attitude towards their own limitations. A curious person has a particular attitude towards discovery. Empathy is an attitude towards other people. Other virtues are more like skills than either attitudes or character traits in the ordinary sense. This is true of lucidity and situational judgement.

This matters because attitudes can be changed and skills can be acquired. People who are advised to change their attitudes aren't being asked to do something that, in general, can't be done. One's attitude towards something is one's posture towards that things, and postures can be changed. The various skills and attitudes listed above can be taught and learned. Self-improvement is possible, at least to some extent, and this should put paid to any idea that the generalist virtues can't be cultivated.

Skills are acquired by training and practice. Attentiveness can be improved by practice and one's situational judgement can be improved by training. Attitudes can't be changed at will but can be changed indirectly by exposing oneself to a wider range of experiences and influences. In all cases, change is easier if one is motivated to change. I have written more about self-improvement elsewhere (see below).

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The 'Person' of 'Whole Person' Medicine

What Is a Person?

What is a 'person'? How do different conceptions of 'whole person' or 'person centred' care conceive of the person, and does medical generalism presuppose a particular conception of personhood? Questions about the nature of persons have received the focused attention of philosophers over a long period of time. So have questions about the nature of the 'self'. These questions are no less relevant to medical generalism, with its emphasis on respecting the person and integrity of the self in whole person care.

For present purposes, the four most directly relevant philosophical approaches to the self or person are the following:

The Dualist View

This view of the self is associated with the French philosopher René Descartes (1596-1650). For Descartes, a person is a union of two distinct things: body and soul. The soul is the true self. It is one's thinking self – the thinker of one's thoughts – and wholly immaterial. The soul or thinking 'I' has none of the spatial properties of material objects like tables. It is not extended in space and has no shape. It is, however, intimately related to something that does have spatial properties: the thinker's own body. One's body is a material thing, a corporeal object among corporeal objects, but does not think. For Descartes, nothing material can think, not even a brain.

Although body and soul are distinct, Descartes realized that the two are intimately connected. Having a body with bodily sense organs and limbs enables the soul to perceive and act. The body is also where bodily sensations like pain are felt. Despite being tied to a particular body, the soul is a separate thing that can outlive the body. The soul is immortal, the body is not.

This view of the soul and its relationship to the body underpins many religions. The philosopher Derek Parfit argues that many non-philosophers believe something like Descartes' view of the relationship between body and soul. In Parfit's terminology, we tend to think of ourselves as separately existing entities, distinct from our brains and bodies. Parfit rejects this view on empirical grounds. Other philosophers argue that Descartes' view is not just false but

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incoherent. Although Cartesian dualism has few takers nowadays in academic philosophy, it is still a significant view if Parfit is right about its popularity outside the academy. For among those who believe that they are embodied souls will be many of the medical generalist's patients.

The Mental Capacity View

In his Essay Concerning Human Understanding (1689), John Locke proposes what is still the single most influential philosophical account of personhood and personal identity. For Locke, a person is a thinking, intelligent being that can reason and reflect and consider itself as itself. To be able to consider oneself as oneself is to have self-awareness, and this is essential to personhood as Locke conceives of it. To be a person, for Locke, is to have certain mental capacities. Anything that has those capacities is a person. Anything that lacks them is not.

Among the striking consequences of Locke's view, one is that personhood is not confined to human beings. Any being, human or otherwise, that has the relevant mental capacities is a person. If a dolphin can reason and reflect and has self-awareness then it is a person. Locke's approach also implies that not all humans are persons. A baby that has not yet acquired the necessary mental capacities is not yet a person and human beings who have lost the relevant mental capacities are no longer people. Here one might think of humans with severe brain damage or advanced dementia.

As Christopher Dowrick notes, if not all human beings are persons in Locke's sense then we have a problem. One way out for Locke is to continue to define personhood in terms of mental capacities but to adopt a much less demanding view of what the relevant mental capacities might be. Dowrick argues, for example, that '*all human beings have some degree of inner conscious presence, a sense of "being me"*' (p. 127) and '*the continuous capacity to be conscious*' (p. 128). If all human beings, including infants and those with severe dementia, have at least these minimal mental capacities, and these are the very capacities that define personhood, then all human beings are persons. On the other hand, the weaker the mental capacity requirements on personhood, the more likely it is that many non-human animals will qualify as people. After all, many non-human animals have the continuous capacity to be conscious.
For Locke, person and human being are different concepts. To classify a being as a person is implicitly to say something about its mental capacities: if it is a person then it has certain mental capacities. The debate between different versions of Locke's view is a debate about what the relevant mental capacities are, and whether they allow all human beings and any non-humans to qualify as persons. To classify a being as a human being is to say something about its species and its biology. A soul – if there is such a thing – would be a person by Locke's lights, but not a human being. God would be a person but not a human being.

Another implication of Locke's theory of personhood is that a person's survival or continued

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existence is fundamentally a matter of psychological rather than physical continuity. Despite all the physical and psychological changes that a person undergoes throughout the course of her life there is still a sense in which it is one and the same person undergoing going these changes. What makes it true that it is the same person is that each stage of her life is mentally connected to preceding stages. Today she can remember what she did yesterday, yesterday she could remember what she did the day before, and so on. Amnesia is potentially a problem for Locke's view it implies that the pre-amnesia person and the post-amnesia person are literally not the same person.

The Biological View

The biological view of persons, also known as *animalism*, says that every person is identical with a particular biological entity, an animal. You are one human animal and I am another. We are different people because we are different human beings. A human being is, in Havi Carel's words, '*a perceiving, feeling, and thinking animal, rooted within a meaningful context and interacting with things and people within its surroundings*' (p. 27) Some animalists allow that non-human animals can be people. Other animalists restrict personhood to human animals. Either way, the one thing that animalists agree about is that personhood is restricted to animals. Robots, however capable, can't be people on this view.

One reason for allowing human beings to count as persons is that they typically have the mental capacities described by Locke. On this account, a patient in an irreversible coma is still a person because he or she is a human being, and human beings are typically thinking intelligent beings who can reason and reflect and consider themselves as themselves. It is also relevant that the comatose person did once have these mental capacities.

The biological view implies that personal identity is fundamentally a matter of biological rather than mental continuity. There is no mental continuity between the comatose patient and the same person before he fell into a coma. What makes them the same person is not that the person in a coma can remember his past life but the fact that it is the same human being before and after. Personal identity is a matter of biological rather than mental continuity because sameness of human being is a matter of biological rather than psychological continuity, that is, continuity of brain, body, sense organs and nervous system.

How does animalism conceive of the relationship between a person and his or her own body? This is how Havi Carel describes the position:

> '*On this view, the body is not an automaton operated by the person but the embodied person herself. We are our bodies; consciousness is not separate from the body. Disease, therefore,*

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> *can no longer be understood as a merely physiological process that affects the person only secondarily*' (p. 16).

The body with which the person is identical is not a mere body but a bodily subject. As well as being an object an object among others, one's body is also the subject of one's experiences and the vehicle of one's consciousness. This is what leads the philosopher Merleau-Ponty to describe it as a '*subject-object*'.

Yet, as Carel notes, in illness one feels betrayed by one's body. The same sense of betrayal by one's body can result from the ageing process. As one's body decays and becomes increasingly uncooperative, one becomes increasingly alienated from it. Having previously been an expression of one's agency, one's malfunctioning body prevents one from doing the things one's wants to do. In being experienced as a hindrance one's body is experienced as *alien*, as not a part of one's unchanged true self. The point at which one finds it difficult to recognize one's body as one's own is the point at which one begins to feel the full force of Descartes' insistence on distinguishing between the body and the self.

The Narrative View

This is how the philosopher Marya Schechtman introduces the narrative view of the self:

> '*If the person sitting next to you on a long plane trip suddenly launches into the story of his life you may be amused, or annoyed, or simply glad for the distraction. Whatever your reaction, you are unlikely to be surprised that he has a story to tell. The idea that our lives are in some way story-like runs deep in our everyday thought*' (p. 394).

According to the narrative view, selves are inherently narrative in structure. In other words:

> '*[W]e constitute ourselves as selves by understanding our lives as narrative in form and living accordingly. This view does not demand that we explicitly formulate our narratives (although we should be able, for the most part, to articulate them locally when appropriate) but rather that we experience and interpret our experiences as part of an ongoing story. The experience of winning the lottery will, for instance, be a different experience for someone immensely wealthy, someone who has lived a life of crushing poverty, and someone who has struggled unsuccessfully with a gambling addiction*' (p. 398).

On this account, it is not possible to explain or describe one's own life in purely mechanical or biological terms. Human beings are animals, but they are also what Charles Taylor calls '*self-interpreting animals*', animals who interpret and make sense of their experiences by relating them

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to an ongoing story, the story of their lives. Crucially, we are self-interpreting animals who interact with other self-interpreting animals in a social context.

Critics of the narrative view object that it is possible to live a rich and meaningful life without having any sense of its narrative structure. It is worth noting that the narrative view is an account of the inherent nature of selves rather than persons. There are many different ways that the narrative structure of a person's life can be disrupted without calling into question his or her continued existence as a person. Alzheimer's can put paid to the narrative integrity of one's life without literally ending one's life. There is a parallel in this respect between the narrative view and the mental capacity view. Both views face the challenge that the mental capacities that they identify as the essence of personhood or selfhood can be lost by human beings who do not thereby cease to be persons or selves. Loss of one's ability to make sense of one's life in narrative terms does not necessarily amount to the loss of one's personhood.

The 'Person' Of Whole Person Medicine

For all the talk of 'person centred' or 'whole person' care, the notion of the 'self' or 'person' is rarely explained. How does medical generalism conceive of the 'person'? Is there a particular view of persons or personhood that underpins the generalist practice?

The 'whole person' orientation of medical generalism is often contrasted with a purely biomedical model of medicine. The latter conceives of patients primarily as biological rather than social organisms and their illnesses as fully accountable at the biological or biochemical level. This seems to fit the biological view of persons. By the same token, it would seem that medical generalists who reject the biomedical model must thereby also be rejecting the biological view of persons, whether they realise it or not.

In fact, this is a gross oversimplification of the actual position. In the first place, the biological view of persons is not committed to the idea that human beings can only be understood in biological or biochemical terms. Animalists can and do accept that people are animals with highly complex mental lives and sophisticated mental capacities, including the capacity to self-interpret. It is therefore only to be expected that an adequate understanding of patients must be biographical as well as biological. According to Iona Heath, medical generalists have to have a biographical understanding of their patients because '*individual biography affects biology*' (p. 94). This is not something that any self-respecting animalist should want to deny.

At the same time, the whole person approach to medicine does not deny that the biomedical model has much to contribute to the generalist's understanding of illness and disease. Hjörleifsson and Lea object to the notion that '*biological approaches trump biographical interpretations of patients' problems*' (p.28) but it is no more plausible that the biographical

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necessarily trumps the biological. The generalist should be in the business of integrating considerations of biology and biography, and does not need to conceive of people as anything other than highly sophisticated biological organisms.

It would be wrong to conclude from this that medical generalism has no use for mental capacity or narrative conceptions of personhood. The mental capacities that are characteristic of persons include both the capacities described by Locke and those identified by the narrative view. Consider this quotation from Toon:

> '*Many people go to their GP not principally because they want to change what is happening to them but because they want to understand it. Is it serious or is it trivial? Will it get better, and how quickly? What impact will it have on their work, their family life, their social and sporting activities? Answering questions like these is an important aspect of health care for which clinicians are ill-equipped by their basic education. It is part of the third aspect of health care, the interpretive function – giving prognostic information and helping patients understand their illness*' (p. 45).

The questions that Toon identifies are ones that can only be asked by beings who can consider themselves as themselves, that is, by self-aware beings who are persons in Locke's sense. The influential idea that generalism has an interpretive function is very much in keeping with the narrative view of the self. The understanding that patients seek from their GPs is an understanding of how their illness fits into the story of their lives and what impact it will have on that story as it unfolds. It is because the 'person' of 'whole person' care is a self-aware and narrative self that helping patients to achieve narrative self-understanding is such a major part of generalist medicine.

If this is right then there is no simple answer to the question 'how does medical generalism conceive of the person?'. In truth, medical generalism takes on board insights from several different conceptions of what it is to be a person. However, one would not be far wrong if one were to say that the 'person' of 'whole person' medicine is first and foremost a self-interpreting animal.

References & Further Reading

The best thing to read on Descartes' dualism is Descartes himself, especially his *Meditations on First Philosophy*.

Derek Parfit's hugely influential account of personal identity can be found in chapters 10-13 of his masterpiece *Reasons and Persons*.

Locke gives his account of persons and personal identity in Book 2, chapter 27 of his *Essay Concerning Human Understanding*.

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The quotations from Christopher Dowrick are from his paper 'Patient, person, self', which appears in his book *Person-centred Primary Care*.

The Havi Carel quotations are from her book *Illness: The Cry of the Flesh*.

Two influential defences of animalism are *Persons, Animals, and Ourselves* by Paul Snowdon and Eric Olson's *The Human Animal*.

My views about the body and the self are set out in my book *Self and World*.

Marya Schechtman's article is 'The Narrative Self', in *The Oxford Handbook of the Self*, edited by Shaun Gallagher.

Charles Taylor's classic paper is 'Self-interpreting animals', which appears in his book *Human Agency and Language*.

The references to Hjörleifsson and Lea, Heath and Toon can all be found in *Defining Medical Generalism*.

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Obstacles to Medical Generalism

Professional Vices

The virtues of a given profession are those qualities that enable members of that profession to fulfil their professional role, achieve the goals of their profession, and meet their professional challenges. Having identified ten professional virtues of generalist medicine something also needs to be said about the range of factors that get in the way of medical generalism, that is, the range of factors that make it harder for medical generalists to fulfil their professional role.

For each professional virtue, there is a corresponding professional vice. For example, if attentiveness is a virtue then inattentiveness is a vice. If humility is a virtue then arrogance is a vice. And so on. The point of classifying inattentiveness as a professional vice of generalism is not to suggest that generalists are especially prone to it. The point is rather to suggest that if one is inattentive then one is less well placed to fulfil the professional role of a generalist than if one is attentive. It is worth noting, however, that inattentiveness and other such failings can simply be the result of overwork, lack of time and fatigue. In these circumstances, it is unfair and inappropriate to censure clinicians for being inattentive.

Are there any vices to which generalists are especially prone? Trish Greenhalgh identifies a tendency to close ranks and an unwillingness to own up to mistakes as two professional vices of clinical practice. These are professional rather than personal vices, to the extent that they affect a clinician's professional conduct rather than their conduct in their private lives. It is an open question, however, whether generalists are especially prone to these vices in their professional lives. A tendency to close ranks and an unwillingness to own up to mistakes sound like professional vices of virtually every profession.

Institutional Vices

Vices are generally understood as personal failings for which the person whose vices they are can fairly be blamed or criticized. Yet many of the most significant obstacles to medical generalism are institutional rather than personal. According to Stefán Hjörleifsson and Kjersti Lea, for example, '*disease-focused clinical guidelines, public health agenda focusing on single diseases and individuals, structured and interventionist electronic records, and expanding medical*

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technologies leave little room for personal interaction between general practitioners and their patients' (p.28).

There is nothing personal about these obstacles to person-centred care, if that is what they are. They are, if anything, systemic obstacles to generalism. If one insists on employing the terminology of virtues and vices one would have to think in terms of institutional rather than personal virtues and vices. That is not as far-fetched as it sounds. Institutions can be more or less bureaucratic, more or less responsive, more or less adaptable. There is no reason not to think of these as institutional virtues or vices.

What are the institutional obstacles to medical generalism? Do they include the factors listed by Hjörleifsson and Lea? In what sense, and to what extent, do disease-focused clinical guidelines, electronic patient records, and expanding medical technologies prevent generalists from fulfilling their professional role? Joanne Reeve notes that while many clinicians welcome a shift from disease-focused to person-centred clinical care '*they also describe clear barriers to delivering this way of working within the constraints of modern healthcare systems and practice*' (p. 160). As described by Reeve, these barriers include the following:

- Current models of service delivery require diagnostic labels to legitimize access to medical care.
- Clinicians lack the time and head space required for the practice of self-focused care.
- There is a lack of training in person-centred care and a fear of working beyond guidelines.
- There is an absence of appropriate systems of learning from self-focused care.

These barriers are not insuperable. However, as Reeve notes, '*to strengthen the generalist, self-focused, approach will need changes in the way we train clinicians and organize healthcare*' (p. 162). In other words, overcoming the institutional obstacles to medical generalism requires systemic change.

The Role of Technology

In a recent paper, Deborah Swinglehurst focuses on electronic patient records (EPRs) and their role in UK general practice. She argues that '*the EPR profoundly changes the dynamics of the clinical consultation and shapes working arrangements and relationships in significant (and sometimes unintended) ways*' (p. 55). For example, GPs spend about 40 per cent of their time in consultations interacting with their computer. It is arguable that there are several professional virtues whose exercise is hindered by the growing role of technology in general practice.

One such virtue is attentiveness. Spending nearly half of every consultation staring at a computer screen and updating the patient's electronic record is hardly conducive to giving one's

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undivided attention to each patient and engaging with their subjective reality. As Swinglehurst puts it, '*the EPR encourages a certain direction of travel – tending to shift towards a privileging of the "institutional" version of the patient over the patient as "individual" or sharpening the tension between institution-centred care (bringing with it additional surveillance and accountability) over patient-centred care*' (p. 72).

Moreover, the computer is a third voice in every consultation, telling the generalist what to do. The EPR, Swinglehurst notes, '*is awash with prompts, alerts and reminders*' (p. 70). According to Greenhalgh, currently when someone visits their GP '*quite a bit of the encounter will typically be taken up by the doctor working through a structured computer template that directs the questions to be asked, the parts of the body to be examined, and the recommended medication*'. She adds that '*if patients knew how much of the consultation was driven by box ticking they would be hopping mad*'.

It is easy to see how these trends might both discourage the exercise of the GP's situational judgement and, in the long run, also diminish levels of professional self-trust and self-confidence. A piece in the *BMJ* notes that:

> '*Inexperienced clinicians may (partly through fear of litigation) engage mechanically and defensively with decision support technologies, stifling the development of a more nuanced clinical expertise that embraces accumulated practical experience, tolerance or uncertainty, and the ability to apply practical and ethical judgment in a unique case*'.

Generalist health care is supposed to be a collaboration between doctor and patient but over-reliance on following algorithmic rules is not conducive to collaborative consultations.

The Guideline Culture and Over diagnosis

The benefits of guidelines are huge. They have been said to improve the quality of care received by patients, improve health outcomes and improve the quality of clinical decisions. However, according to Greenhalgh and her colleagues, heavy reliance on guidelines can also '*crowd out the local, individualized and patient initiated elements of the clinical consultation*'. The heavier the reliance on general guidelines the harder it is for the clinician to engage with the fine-grained particularity of each individual patient.

The guideline culture and technology have also been blamed for the growth and institutionalization of overdiagnosis and overtreatment. In the words of Julian Treadwell and Margaret McCartney:

> '*Advancing technology allows detection of disease at earlier stages or "pre-disease' states. Well-*

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> *intentioned enthusiasm and vested interests combine to lower treatment thresholds and intervention thresholds so that ever larger sections of the asymptomatic population acquire diagnoses, risk factors, or disease labels. This process is supported by medicolegal fear, and by payment and performance indicators that reward over-activity. It has led to a guideline culture that has unintentionally evolved to squeeze out nuanced, person-centred decision-making*' (p. 116).

These are illustrations of just some of the institutional and technological obstacles to generalist medicine. There are, no doubt, many others. Much could be also said in this connection about the increasingly managerial culture of institutions such as the NHS. The payment and performance-indicators referred to by Treadwell and McCartney are integral to this culture. They are a powerful illustration of the tension between managerialism and the distinctive methods, orientation and objectives of medical generalism.

These obstacles are by no means insuperable. For example, there is nothing wrong with an evidence-based approach as long as it prioritizes the care of individual patients and is not allowed to obstruct real shared decision-making. The deeper point, however, is that many of the most serious challenges to medical generalism are institutional rather than personal. The remedies are therefore also, to a large extent, institutional rather than personal. Of course it is desirable for medical generalists to cultivate the virtues of generalist medicine, but the systems in which they work must also allow for the unhindered *exercise* of these virtues.

References and Further Reading

The reference to a tendency to close ranks and an unwillingness to own up to mistakes is from here: https://www.cebm.net/2016/01/5395-2/

The article by Hjörleifsson and Lea is '*Mismanagement in general practice*', in Christopher Dowrick (ed.) Person-centred Primary Care: Searching for the Self.

The article by Deborah Swinglehurst is '*Challenges to the "self" in IT-mediated healthcare*', also in the Dowrick volume.

The benefits of clinical guidelines are summarized here: https://www.bmj.com/content/318/7182/527

Greenhalgh's comments about what happens when someone visits their GP are from this report in the BMJ: https://www.bmj.com/content/349/bmj.g4443

The quotation about the use of decision support technologies by inexperienced clinicians is from this article by Greenhalgh, Howick & Maskrey: https://www.bmj.com/content/348/bmj.g3725

The account of the causes and consequences of overdiagnosis is from this article by Treadwell & McCartney: https://bjgp.org/content/66/644/116/tab-article-info

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