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REVIEW ARTICLE

Professionalism in anaesthesiology practice: ethical reflection on the nature of professionalism in anaesthesiology

Malcolm de Roubaix[a]*

[a]*Department of Philosophy, Centre for Applied Ethics, University of Stellenbosch, Stellenbosch, South Africa*
**Corresponding author, email: malcolmderoubaix@gmail.com*

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Anaesthesiologists are well trained and equipped to practise a high standard of care and contribute significantly to positive perioperative outcomes. Professionalism is characterised first by expertise in the clinical skills, capabilities, knowledge and experience internal to the practice of anaesthesiology (or a sub-specialty), and the knowledge, understanding and practice of the professional duties associated with anaesthesiology. Relatively recently it has been realised that more than good training and clinical expertise are required if anaesthesiologists want to practise as true professionals. This requirement relates to personal behaviour and attitudes that can loosely be labelled as *moral attributes*. The article argues that these moral attributes may best be understood with reference to Aristotle's notion of virtue ethics—the idea that character and virtue are important in ethics. Though this is the central theme of the article, a more comprehensive picture is provided of what it means to be a professional.

Keywords: professionalism, anaesthetic practice, professional duty, ethics of responsibility, virtue ethics, Aristotle

Introduction

Based on unprecedented scientific, pharmacological and technological developments and a vastly enhanced understanding of (patho)physiology, and associated skills, anaesthesiologists perform a key function to ensure optimal preoperative preparation and perioperative care and outcome, and have become true professionals. Our specialty rests on twin pillars of sound, developing science and professionalism. The purpose of this article is to explore the concept of professionalism in anaesthesiology. Notwithstanding a more comprehensive discussion, the focus will be on the moral attributes of professionalism, and the renewed interest in the role of character and Aristotelean virtue ethics in contextualising these moral precepts.

Professionalism in anaesthesiology

There have been many approaches to and attempts to define professionalism in the practice of medicine and anaesthesiology, of which I shall mention a few. A joint Euro-American Physician Charter on Medical Professionalism includes three fundamental principles (primacy of patient care, patient autonomy and social justice), and 10 professional responsibilities and commitments (professional competence, honesty in dealings with patients, respecting patient confidentiality, maintaining appropriate patient relations, improving quality of and access to care, distributive justice vis-à-vis resource allocation, scientific knowledge, maintenance of trust by declaring conflicts of interest, and professional responsibilities).[1]

McKenna and Rosen emphasise that the present societal expectations of medical professionalism relate to specific skills, attitudes and behaviours expected of practitioners. These include adherence to the core principles of biomedical ethics, the medico-legal and regulatory facets of practice, maintenance of personal health and career sustainability, management of adverse events, quality improvement and remedial programmes as required.[2]

Freeman and Berger discuss four basic components of professionalism: ethics (honesty, integrity, highest possible moral standards); accountability (primacy of patient interests); humanism (appropriate doctor–patient relation); and mental and physical physician well-being.[3]

Ellison contends that 'competence, confidence, compassion and integrity' are four key ingredients of professionalism, and captures the moral nature of professionalism in the following citation:

> 'Professionalism starts with a commitment to achieve something more satisfying than immediate personal gain and requires a commitment and devotion to quality, excellence and personal sacrifice that goes beyond an eight-hour day. Professionalism must rest on a solid base of education, experience and skill and must encompass real respect for other professionals as well as patients.'[4]

Daniels reiterated that whilst there are many connotations to professionalism (e.g. remunerated occupation, requiring special training/regulation and performing some necessary and respected societal service), in the final analysis professionalism denotes something more, i.e. some sort of *moral* content.[5]

Lastly, Hope, Savulescu and Hendrick note five features of medical professionalism: commitment to important public service and good; special knowledge and training; self-regulation and upholding professional standards; certification and overall regulation by, e.g., the HPCSA.[6]

Developing the above we can group the connotations of professionalism under two headings. First, the possession of the requisite clinical skills, competencies, knowledge and experience internal to the practice of anaesthesiology (or sub-specialty), and consequently knowing, understanding and practising the associated duties (one could call these clinical entry requirements). In a sense, these are imposed upon us. But if we follow the reasoning above, there is a second requirement which relates to personal behaviour and attitudes that we can loosely label as *moral attributes*, which are not imposed upon us in the same way and with the same authority as the first set of

requirements but which professionals should embrace individually and as a group. The appreciation of the significance of these values and attributes to ensure ethical practice is a relatively recent development. Moral attributes are intrinsic to the professional nature and character of professionals, though they also apply to society generally and to all (non-medical) professions, and to each in a specifically applied manner. In the ensuing it will become clear that though they are discussed under separate headings, the divisions between the more clinical and moral aspects of professionalism are not necessarily sharp, and are possibly artificial, and that they influence and complement each other and operate simultaneously, as is demonstrated in the CanMEDS key competencies framework of medical expertise[7]. The ethical aspects of any action should be the subject matter of internal reflection before, during and after the deed, and shape the nature of the deed; indeed, reflective practice implies a practice of continued improvement and learning through constant reflection and reflexivity[8]. I nevertheless use separate headings in order to emphasise each. We first examine what I have labelled entry-level requirements.

Clinical entry requirements, continued professional development (CPD) and professional duty

The contemporary practice of anaesthesiology requires high standards of knowledge, skills and expertise, which should remain abreast of the latest developments; patients are entitled to and do place their trust in the professional's ability to deliver on her/his promises and agreements and provide the kind of service associated with excellence in anaesthesiology, and these are the standards by which we should hold ourselves to account, and be held to account by others. In the words of the American Society of Anesthesiologists (ASA) practice guidelines:

> 'The achievement and maintenance of competence and skill in the specialty is the primary professional duty of all anesthesiologists. This responsibility does not end with completion of residency training or certification by the American Board of Anesthesiology.'[9]

We should therefore not see CPD requirements as irritating impositions but as necessary (minimum, not maximum) requirements to maintain knowledge and clinical ability. I doubt that present standards and methods of CPD are optimally effective when they rely on passive learning in the form of lectures, which may not be ideal without follow up. Specific hands-on workshops are offered, but are not compulsory. Compulsory workshops and periodic short residencies (say, one month in a five-year cycle) should be investigated as a means to attain the ends of CPD if we are serious about optimal patient care and safety.

But the scope of modern anaesthetic practice implies that we cannot be experts in all fields. Professionals should practise within the bounds of their ability, experience and expertise. There is little room for casual exposure to uncommon conditions (e.g. rare pathology like pheochromocytoma) and situations (e.g. neonatal surgery) unless unusual circumstances dictate; saying 'no', 'I don't' or 'can't' for the right reason does not denote that we are lesser beings; on the contrary.

Practice guidelines, so-called *ethical rules* and *legislation* guide the practice of anaesthesiology and define *professional standards and duties*. Guidelines include those issued by the SA Society of Anaesthesiologists (SASA; available on their website[10]), the SA National Patients' Rights Charter (2008[11]), chapters 2/6 and 2/7 of the National Health Act dealing with informed consent[12], and the various practice guidelines and ethical rules issued by the Health Professions Council of SA (HPCSA),[13] with which anaesthesiologists should be familiar. These professional guidelines and duties are important in practice and we are obliged to comply with them. Although often referred to as *ethical* guidelines, ethics in this context has a meaning restricted to conduct described in the various guidelines and not to morality as such. Besides, for many moral philosophers (ethicists) the moral status of rules and laws is ambiguous. Contrast for example two influential post-enlightenment schools of thought supporting opposing views in this respect: rule-based deontological ethics, of which Kant's ideas are perhaps best known[14], and outcome-based utilitarian (consequentialist) ethics[15]. Immanuel Kant's notions on the validity of moral rules is summed in his so-called Categorical Imperative (first formulation): 'Act only in accordance with that maxim through which you can at the same time will that it become a universal law.' For deontologists, the intention of the moral agent is more important than final outcome[14]. Jeremy Bentham and John Stuart Mills argued the opposite, i.e. that the nature of deeds and intentions of agents are unimportant; in judging the ethical nature of actions, only consequences matter (consequentialism).[15] The practice of medicine illustrates that seemingly opposite ethical positions may need to be integrated to produce the desired results; in medicine, both intentions and outcomes matter. Postmodernists, representing a more recent school of thought, argue that true morality and rules are incompatible; where rules are made applicable, morality is no longer required because all that is required is appreciating and applying the appropriate rule, not the reflection and anguish that often accompanies deliberating real moral decisions (p. 76).[16] Nevertheless, rules serve a moral purpose. First, they provide guidance (in the present context) for practitioners in instances that have by and large been settled ethically (e.g. in negotiating informed consent). Second, rules have a moral aspect related to how we elect to honour them, once we decide their applicability. After all, we make an implicit promise to our patients that we will practise accordingly. Postmodernists contend that rules (or laws) should be applied with *responsibility*, not blindly but taking context into consideration, and may be broken (indeed, should be) when they are unjust, unfair or contrary to the moral others' interests. Two examples from our recent past illustrate the consequent dilemma of conflicting duties: discriminatory apartheid rules dictated that blacks and whites be separated in all state hospitals, and facilities for blacks were often inferior. Second, contrast the actions of the doctors who initially mistreated Steve Biko with those of the state pathologist who ignored his responsibility to his employer (the State) by leaking his post mortem findings to the press, thus exposing the true cause of Biko's death (head injuries sustained while in custody).[17] A responsible professional does not blindly follow rules, nor is she uncritically loyal to employers and authorities.

The appreciation of professional duty becomes ingrained during training through precept and example, as is the capacity to accept responsibility. An ethics built around the acceptance of responsibility (meaning both accountability and duty of care) has been argued as the fundamental motivation to practise medicine, implying that we accept a very special type of responsibility for the welfare of our patients.[18] Professional responsibility can be conceptualised both as a responsibility *for*, but also *to* our patients. We are responsible (accountable) *to* when we interact with non-anesthetised patients and other professionals and lay persons with whom we are required to

negotiate informed consent, to whom (including regulators) we are obliged to explain our actions and who, in turn, can demand accountability from us for our actions/inactions; and *for* the well-being of patients under our care, temporarily incapacitated and vulnerable (anaesthetised, in recovery, or in ICU and/or cannot judge or fend for themselves), and who are entitled to and expect care of the highest standard. The notion of responsibility as originally argued by Hans Jonas[19] and Zygmunt Bauman (p. 92)[16] is onerous; for them, responsibility has no limits, spans time and place, asks not for reciprocity and is offered to all who need it, irrespective of ability to pay or actually requesting it. For Bauman, the recognition of need in our fellow human beings, having the ability to respond to that need, and ultimately responding appropriately ignites the spark of personal morality; we become moral persons when we accept and practise responsibility (pp. 17–31).[16] This notion underlines the primacy of patients' interests, and the dedication and personal sacrifice that often characterise the practice of medicine and are part and parcel of the professional duty that the responsible practitioner accepts. Considering the commercial nature of twenty-first-century medicine, this notion of responsibility seems unrealistic and arcane. Yet the fact that responsibility taken to this ultimate apex is probably impracticable attests less to what is wrong with this notion and more to what has gone amiss with the practice of medicine. And even if societal restraints and developments limit the ability to practise responsibility to this level (we may, for instance, be accused of paternalism, and there may be a 'thin line between care and oppression'[16]), practising any branch of medicine without a well-developed notion of professional responsibility is unimaginable. We may not reach Bauman's zenith, but may aspire towards it….

Professional responsibility extends outside of the intimate professional arena; for example, professionals should be agents of change when unjust societal norms, laws and regulations impact on the treatment or humanity of patients. They should be activists within their society, hospital, organisation or practice to optimise the quality, safety, efficiency and efficacy of service delivery. This can best be brought about by being active members of professional societies like SASA, by serving on appropriate bodies within public or private sector institutions and other appropriate political activities and actions. Self-regulation is an important professional responsibility that applies to both the individual and the collective. The individual professional should have the moral compass, integrity and strength of character to do what is clinically and morally correct under given circumstances, always considering patient interests as of prime importance. Another professional responsibility is the development and monitoring of standards of care, training and CPD, and of mechanisms to investigate and adjudicate when standards are not met, professionals are incapacitated, adverse events occur and remedial steps are required. SASA and the College of Anaesthetists perform this function, but hospital departments and practice groups should too, on a different level. In the final analysis, all professionals act as their own judges.

Professionals have the responsibility to interact with mutual courtesy and respect both within and outside of their specialty with the ultimate aim of optimal patient care, and to respond appropriately when encountering incompetence or ethical transgression in colleagues.

Medical professionals and, due to the nature of their work, particularly anaesthesiologists, should maintain *physical and mental acuity* through an acceptable life- and practice style. On the one hand this underlines the personal sacrifice that characterises the life of a medical professional; on the other it urges professionals to organise their practices to allow room for adequate time off and relaxation to ensure sustainability and stability.

Let us now reflect on the moral aspects of professionalism, bearing in mind that the clinical and moral aspects of professionalism are one integrated and indivisible whole.

Moral attributes of professionalism

Does one need to be a 'good' person in order to do ethically 'good' deeds? Of course not (all humans are capable of both good and evil!), yet, on balance, a person with a sound character is likely to reason in a way that predisposes to decisions and actions of a certain nature, and is more likely to get it right. This does not simplify ethical decisions and reduce them to intuitions, or obviate the necessity of appreciating and where necessary applying the tools necessary to make ethical decisions—being familiar with and applying the principles of ethical reasoning, and appreciating that, depending on the nature of the dilemma, we may need to integrate principles derived from various approaches to ethics to solve a particular dilemma. Decision-making is only one step in a chain of events that can lead to ethical deeds, and moral character traits or virtues like perseverance and integrity are required for the final and sometimes most onerous step: actually implementing decisions. It is at this final step—applying what one discerns to be right—that humans may fail (e.g. criminals almost always know that their deeds are illicit and harmful).

The notion that the character of the agent is important in ethics dates back more than two millennia and is today predominantly associated with the work of the ancient philosopher Aristotle. In his *Nicomachean Ethics*, Aristotle argued that morality can best be understood with reference to certain acquired human characteristics which he called *virtues* (*arête*). This approach to ethics is known as virtue ethics. Everything in life, argued Aristotle, has an ultimate aim or *telos* (if you drop a stone its telos is to come to rest on the ground); through leading a life characterised by these virtues, the ultimate aim of human life can be attained—namely, happiness or well-being (eudaimonia) achieved by habitual application of practical wisdom, confronting each situation and choosing the right course of action in every case. Thus, even though the 'aim' of ethics is outwardly directed to the way in which I interact with others, the practice of these virtues leads to happiness defined as *living well*. For Aristotle eudaimonia and a virtuous lifestyle are inseparably linked, determining how we should conduct ourselves in society.[20] In Aristotle's own words:

> 'As traits of character, virtues are neither one-time only actions nor merely intellectual conclusions. Instead, they are dispositions regarding actions, perceptions and emotions of the right sort, toward the right subjects, for the right end, at the right times and in the right way.'[20]

Kant's deontological ideas[14], Bentham's and Mills' consequentialism[15], and a number of other theories of ethics have overshadowed virtue ethics. There have nevertheless been periodic resurgences in the popularity of virtue ethics, the most recent consequent to Alasdair MacIntyre's influential *After Virtue.* MacIntyre argued that the post-Enlightenment philosophical traditions (deontology and consequentialism) have failed to produce a coherent, rational account of morality, and that the

answer was to be found in returning to Aristotelean traditions (adding some ideas from St Thomas Aquinas).[21] There remains strong support for the notion that the character of the agent is important since it influences the nature of decisions made, and a simultaneous reappraisal of the role of virtue ethics in medicine has taken place.[22–24]

Virtues are positive characteristics like courage, humility and frugality that predispose to customarily acting in a certain manner … making ethics a very practical discipline. In Nichomachean Ethics, Aristotle lists about 11 so-called 'moral' virtues (courage, temperance, liberality, magnificence, magnanimity, proper ambition, truthfulness, wittiness, friendliness, modesty, and righteous indignation; each applied in a particular setting), and three 'intellectual' virtues (intelligence, science and theoretical wisdom or logic). He also mentions good sense, understanding, practical wisdom and craftsmanship as virtues. Moral agents, argued Aristotle, should develop the expertise to know *how to apply* each virtue in particular circumstances; this through the *doctrine of the mean*, calling to mind reasoned appropriateness rather than calculable average (p. 28).[23] For example, in the face of danger, courage is the appropriate mean between rashness and cowardice and in contemplating charity, generosity the mean between wastefulness and stinginess. Note that courage and generosity are the virtues in question, not the excesses at either end (which may be vices). Through practical exposure and experience as fledgling members of society, young people gradually develop wisdom (practical intelligence or phronesis in Aristotle's vocabulary), which directs them to find the mean between excesses. Thus human actions are 'guided by wisdom through which we appreciate the true character of individual and community welfare', the ultimate aim of morality. Ethically correct action involves aligning our desires with the latter; we practise the virtues not for personal gain but for the benefit of society.[25]

To apply the Aristotelian analysis implies that we need to take some liberty and define the virtues applicable to anaesthesiology. The list is really endless and includes virtues like sincerity, honesty, moderation, diligence, patience, kindness, humility, temperance, charity, accountability, assertiveness, benevolence, beneficence, bravery, caution, commitment, compassion, consideration, contentment, courtesy, curiosity, dependability, detachment, determination, devotion, diligence, discernment, discretion, discipline, duty … and that just exhausts the ds if not the reader! I will pick just a few from the rest of the alphabet: empathy, enthusiasm, focus, friendliness, gentleness, helpfulness, honesty, hope, humility, integrity, justice, kindness, knowledge, liberality, loyalty, magnanimity, meekness, openness, punctuality, reliability, respect, restraint, reverence, selflessness, service, sincerity, sobriety, tact, thrift, tolerance, truthfulness, wonder and zeal.[26] The experienced practitioner may recognise moments in her/his professional career when she/he was required to practise each of these virtues and may reflect on the meaning of each, and how they were/should be applied (adding her/his own to the list). Patients, colleagues, other members of the healthcare team, administrators, the legal profession and the public may on occasion be able to judge us by the expression of these moral traits in our daily practice, but in many less obvious decisions knowledge thereof will be restricted to the anaesthesiologist. For a dedicated professional there can be no better recompense than the satisfaction derived from knowing that a task was performed optimally, both ethically and clinically. In the Aristotelean sense we might argue that this is the *telos* or true aim and purpose of the professional. The reader will no doubt have recognised that none of these virtues are unique to anaesthesiology; rather, they are laudable character traits all members of society should hold dear.

But virtues cannot be taught in a lecture room setting. 'Training' in virtue ethics starts at home, and develops in societal intercourse, accentuating the responsibility of each societal member to live virtuously; we perpetuate the society we create. Contemporary undergraduate and postgraduate courses contain ethics modules, but these do not focus on virtue ethics. The examples of peers and role models to develop and strengthen innate virtues are important in this respect. The development of the ability (non-Aristotelean virtue?) to reflect, particularly to self-reflect, on how and why to act virtuously in the face of societal and personal challenges, and to learn reflectively, and the phronetic wisdom to know how to apply the virtues, signal the development of responsible adulthood.

A virtuous anaesthesiologist would have a particular approach to solving ethical problems, though recourse to other notions and the capacity for ethical reasoning are also required, and we require the phronetic wisdom to practise each virtue appropriately. And this, Aristotle would also argue, comes with appropriate societal knowledge and experience. We can contextually define 'society' as the broader society of anaesthesiologists, which in turn points to our individual and collective responsibility to act as such a society, and the responsibilities of such a society vis-à-vis its members, their patients and society at large.

To get back to the question whether only virtuous persons can be 'good' anaesthesiologists … my final response is measured; even though my argument is limited to the professional practice of anaesthesiology (and medicine in general), I find it difficult to conceive how one can totally divorce a professional from a private persona.

Conclusion

I conclude with this quote from Ellison, who says it all:

> 'Professionalism starts with a commitment to achieve something more satisfying than immediate personal gain and requires a commitment and devotion to quality, excellence and personal sacrifice that goes beyond an eight-hour day. Professionalism must rest on a solid base of education, experience and skill and must encompass real respect for other professionals as well as patients.'[4]

Appropriate application of moral virtues can guide professionals to act in accordance with these lofty ethical ideals. There is a renewed appreciation that the character of the moral agent, though not an intuitive moral short-cut, contributes to sound ethical decision-making

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