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Ethics of virtue applied to medical deontology

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Abstract

Throughout history, medical ethics has taken on different perspectives. Nowadays, the indisputable understanding seems to be that of the supremacy of normative ethics as the one that best meets the needs of the relationship between medical professionals and their patients. Given this context, this investigation sought to understand how the ethics of virtues can contribute so that medical deontology can be effective and virtuous targeting the well-being of patients. To seek this understanding, a bibliographic search of narrative and critical theoretical-conceptual character was carried out. The hypothesis is that although deontology is the most accepted and practiced guide in the professional-patient relationship, if it is not accompanied by an ethics of virtue to guide medical action, there is no guarantee that the mere fulfillment of the rule is virtuous with regard to the patient's well-being.

Keywords: Ethics, medical. Virtues. Ethical theory.

Resumo

Ética das virtudes aplicada à deontologia médica

Ao longo da história, a ética médica assumiu diferentes perspectivas. Na atualidade, parece haver indiscutível supremacia do entendimento de que a ética normativa é aquela que melhor atende às necessidades da relação de profissionais da medicina com seus pacientes. Nesse contexto, esta pesquisa buscou investigar como a ética das virtudes pode contribuir para que a deontologia médica possa ser eficaz e virtuosa com vistas ao bem do paciente. Para buscar essa compreensão, realizou-se pesquisa bibliográfica de caráter teórico-conceitual narrativa e crítica. A hipótese levantada é de que, embora a deontologia seja o guia mais aceito e praticado na relação do profissional com o paciente, se não for acompanhada de uma ética das virtudes para orientar a ação médica, não há garantias de que o mero cumprimento da regra seja virtuoso no que tange ao bem do paciente.

Palavras-chave: Ética médica. Virtudes. Teoria ética.

Resumen

Ética de las virtudes aplicada a la deontología médica

La ética médica adoptó diferentes perspectivas a lo largo de la historia. Parece existir actualmente una indiscutible supremacía de que la ética normativa es la que mejor responde a las necesidades de los profesionales médicos y sus pacientes. Por tanto, esta investigación buscó evaluar las posibles contribuciones de la ética de las virtudes para que la deontología médica pueda ser eficaz y virtuosa con vistas al bien del paciente. Para comprenderla, se realizó una investigación bibliográfica teórica-conceptual narrativa y crítica. Se partió de la hipótesis de que cuando la deontología, a pesar de ser la guía más aceptada y practicada en la relación del profesional con el paciente, no va acompañada de una ética de las virtudes destinada a guiar la conducta médica, no está garantizado que el mero cumplimiento de las reglas la haga virtuosa con respecto al bien del paciente.

Palabras clave: Ética médica. Virtudes. Teoría ética.

Update

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The training of healthcare providers, especially physicians, has prioritized training and education related to technical and scientific aspects. Thus, their lack of training in ethical and bioethical issues related to their practice means that physicians' knowledge in this area is usually restricted to a discipline taught in the early stages of their undergraduate courses. Once trained, most of these professionals only have contact with ethical and bioethical issues related to the guidelines of the Code of Medical Ethics (CEM) [1], especially when a colleague or medical professional gets involved in the violation of some of these principles, and what happened becomes public knowledge.

In the continuing education of physicians, as in scientific events and congresses, in their different fields and specialties, ethical and bioethical issues occupy a marginal place. These discussions usually take place informally in conversation circles, especially when practical cases involve other colleagues.

Healthcare providers' reductionist understanding of ethics and bioethics, limited to the CEM, is quite harmful because it reinforces the idea that the ethics which should guide medicine is only deontological, with their sanctions and penalties provided for in the CEM itself. In other words, the current academic and scientific structure reinforces the medical culture that a single ethical approach is to be known and feared: the deontology defined by the CEM of the Federal Council of Medicine (CFM).

However, in the exercise of their profession, healthcare providers face many ethical and bioethical problems and dilemmas without obtaining adequate training, which impairs their capacity to deliberate toward patients' good [2]. In this context, this study points out that—having medicine as a *télos*, or the ultimate goal of doing good to patients—as stated by the *Hippocratic Oath*), physicians must have received training that includes ethical issues and bioethics to achieve this purpose, going far beyond the deontological training limited to the CEM.

It started from the premise that training based on the ethics of virtues, which contributes to physicians' character, would enable them to comply with deontological ethics not as an instrument of coercion and fear but as a direction in search of the best path for the good of patients. We also sought to historically analyze deontological medical ethics and its presence as an exclusive ethical guide in the conduct of the CEM in its most recent edition [1]. This is a theoretical-conceptual reflection based on a review of narrative and critical literature supported by texts on medical philosophy and ethics.

Medical ethics and its changes from a historical perspective

For a long time, medical ethics was based on the paradigm that physicians had a technical, ethical, and religious superiority. This condition guaranteed them the practice of medicine in a patriarchal way, that is, in addition to their ability and technical-scientific knowledge, physicians had the moral power to know what was best for patients. All that was left for patients was a subjection to physicians' knowledge and power [3].

This superiority of physicians was also found in other professionals, such as politicians, judges, and priests in their respective fields of activity. One of the hallmarks of these professions is that they are not measured by common moral standards [4]. On the other hand, the sick belonged to the common social body, subject to ordinary morality. Thus, as they were considered incapable of deciding what would be best for themselves, patients could only follow the decisions and recommendations established by physicians.

In this context, Gracia recalls that, throughout Antiquity and the Middle Ages, medicine was guided by the ethics of Greek virtues and that *Greek virtue was aristocratic* [5]. Only physicians would be responsible for choosing what would be beneficial, as can be seen, like the paternalism concerning Hippocrates and his oath [6].

The society in which Hippocrates lived was aristocratic and deeply influenced by the virtue ethics of Socrates and Plato. As it predates Aristotle, he built his *Corpus hippocraticum* under the ethical precepts of the aforementioned philosophers and the culture of his time [6]. The *Hippocratic Oath was a text written in precise coordinates of time and place, and only there it acquires meaning* [7]. Therefore, the oath has an eminently extra-legal character, understood as irrevocable, unlike a legal contract, which could be revoked and dissolved by the mutual agreement of both parties.

From Antiquity up to the late Middle Ages and early Modern Age, the responsibility classified as solid or moral would only be that of physicians, jurists, and priests. On the other hand, weak or legal responsibility would be that linked to all other activities, called crafts. In this sense, common, weak, or legal morality could be considered revocable insofar as, if in joint agreement, parties would undo their moral ties [3]. However, physicians' morality was an antipode of legal morality due to its irrevocable character.

The *Hippocratic Oath*, markedly priestly, was the only moral guideline for medicine for more than 15 centuries. According to the Greek understanding of the oath, physicians' commitment to patients is made virtuously, making it irrevocable. If it were revocable, medical ethics would need to submit to the legal ethics of other crafts [3]. This role is characterized by having the domain of beneficence, which was understood as paternalism in ancient Greece.

The change in this paradigm began, in a more seminal manner, in the late Middle Ages, in which students graduated from universities to carry out activities which had the *status* of a profession: theology, law, and medicine. With the end of that period and the beginning of Modernity after the French Revolution, medical moral authority began to be rethought and questioned. In this phase, the modern State was solidified under the recognition of established laws, the right to command these laws, and the exercise of State authority [3].

Moral authority was gradually replaced by legal authority, and dominion came to be based on the laws from which the system of bureaucratization and State command emerged. Medicine came to be understood as an everyday work activity subject to the ethical premises of any other profession and subordinated to the deontology of social, commercial, and legal rules common to all.

Codes of ethics replaced classic oaths and ethics became deontology. Gracia states that *the modern world arises when people understand themselves as moral and not physical realities* [8], which the author classifies as a paradigm crisis. In other words, the change in social paradigm forced a change in the ethical paradigm of medicine.

With the beginning of Modernity and its socioeconomic and political changes, economic freedom gained strength. It was based on the understanding that all produce the most they can for the common benefit [3]. This liberal model sought a certain control of the State, subjecting society to reasonable ethical and legal standards. The difference was no longer between the state of nature, as defined by Hobbes [9], and civil society, but between the public (civil) and private (personal and family) spheres, so autonomy began to be valued more than paternalism.

Although the social, economic, and political changes of Modernity were the context for also demanding changes in medicine, it can be said that it, in a way, resisted the changes of Modernity and that a broader revision of medicine only took place in the 20th century.

In the 1970s, the so-called movement for the rights of sick people arised and bad professionals, classified as *spiritually perverse* [10], began to receive much criticism. On the other hand, albeit slowly, the physician-patient relationship, which was vertical and paternalistic since the beginning of the practice of health care, gradually began to become horizontal, as did other social relationships, such as parents and children and employers and employees. In place of paternalistic rule, shared responsibility emerged, and, little by little, that conception of superior and inferior morality disappeared [4].

The morality that is formed takes place at the public level or in an idea of minimum ethics and common to all professions and occupations and must be governed by the principles of non-maleficence and justice, having as an essential guide the requirement of legal responsibility. In the perspective of maximum ethics, autonomy and beneficence must prevail at the private level. Thus, regardless of occupation, one must act under the veil of a single ethical model, respecting the autonomy of social agents and allowing them to define what they understand by beneficence [4].

Traditional professions were no longer able to support themselves in the old paternalistic paradigm and, at the same time, had difficulty adapting to a new model. This lack of certainty about how to act often ends up in professional attrition, demoralization, and confrontation between the poles involved in this relationship.

The movement for the rights of sick people also ensured the granting of informed consent. Thus, patients' right and will would also be respected, guaranteeing the liberal model, in which freedom of choice is understood as a right. This is guaranteed by law and defended in the courts. Such norms must occur at a public level or in an idea of minimum ethics and common to all professions [4].

Ethical foundations in the *Hippocratic Oath*

The *Hippocratic Oath* was erected under the social, cultural, and ethical veil of the Greek world, with a solid paternalistic and priestly tendency. Inspired by the virtue ethics of Socrates and Plato, the oath, says Gracia, *is a text written in precise coordinates of time and place and only there it acquires meaning* [11].

The model of virtue ethics was later systematized by Aristotle, especially from his *Nicomachean Ethics*. In the view of Greek society and the cultural foundations on which the entire philosophy of Socrates, Plato, and Aristotle was built, individuals would never be considered equal. The differences between them were accepted as natural in *physis* and countless human activities would be carried out with different degrees of importance and complexity [12].

In the scope in which Hippocrates wrote the oath, *physicians* (...) *commit themselves to a strong responsibility, hence a priestly character* [13], with a total, absolute, and perpetual surrender. In other words, a surrender as expected from parents to children or from a priest to his followers, which characterizes its eminently extra-legal character: *the commitment of the oath is not juridical but priestly. Furthermore, this priestly sense imposes legal impunity* [14].

As an oath based on virtue (*areté*), its ethics are mostly beneficent since the moral attitude of the medical act generates benefits for patients. Therefore, the medical professional must be virtuous or, in ancient and current terms, have moral and intellectual excellence. From the understanding of the Greek *ethos*, physicians must and can say what is good for their patients.

The attitude of patients was based on the certainty that physicians, who were more virtuous, would seek their good. Thus, the words in *the Hippocratic Oath* are identified as referring to a paternalism which prevents patients from exercising autonomy and deliberation [6].

Deontological ethics

The knowledge accumulated in history is expressed as laws and norms to be learned, understood, and followed for life in society. Individuals are led, induced, trained, and directed to follow the rules: this is called deontology. Until the 16th century, despite the existence of legal and religious codes with a totally deontological bias, when ethics was a philosophical study, it was mainly based on the so-called virtue ethics, which arrived via the philosophy of Socrates, Plato, and Aristotle. An alternative to this model can only be found in Immanuel Kant [15], with the ethics of reason, in the 18th century.

Unlike the Greeks, Kant sought, without resorting to God, a concept familiar to all individuals. For him, this parameter can be found in reason since we differ from animals for having reason [15]. This allows us to accept that all human beings have the possibility of having a common ethical framework to recognize what should be carried out, as long as their reason supports it.

This philosophical speculation allows us to understand that reason is responsible for motivating individuals to change their mundane approach to will, ceasing to see it as purely synonymous with freedom to understand it as the result of a reflection arising from reason: freedom is being able to do everything that is rationally allowed and, thus, reason is understood as synonymous with freedom. Thus, for Kant [15], will would become good will. Total freedom is achieved by acting in the fulfillment of what must be done. It occurs from good will, which, in turn, becomes the driver of actions to fulfill duties.

The existence of—*a priori*, universal—moral concepts as the basis of ethics allows the individual to define what is good or bad even without a previous experience, says Kant [15]. Believing that moral concepts are part of everyone's rationality, the philosopher establishes that moral action

is based only on reason [12]. The individual's reason is the engine of their autonomy and, when moved by reason, this will lead them to the most morally correct choices for themselves and the community in which they live. Human reason, therefore, will autonomously lead the actions of human beings under the aegis of the maxims of duty [15].

Kant would only consider some law or moral norm as a maxim if it could be tested and pass the examinations in the face of general moral rules, which he defined as a categorical imperative, that is, a commandment of reason: *act only in accordance with that maxim through which you can at the same time will that it become a universal law* [16]. It follows that, by being linked to compliance with laws and norms tested and approved by the categorical imperative, they would be rationally respected by all human beings without distinction. Thus, his ethical model is classified as deontological ethics.

Deontology starts from the idea that the law or the norm determines good or evil, right or wrong. In other words, good and evil are not prior to the moral law but are defined in it, and only moral law makes something worthy of being classified as good or evil.

In the West, which understands that some law or rule establishes right and wrong from an early age, it is unsurprising that a medical bioethical guide became the driver of biomedical ethics. This happened with the 1979 work by Beauchamp and Childress entitled *Principles of Biomedical Ethics* [17]. Inspired by the *Belmont Report* (1978), in whose team Beauchamp participated as a member, the authors state that the principles which should guide biomedical ethics are autonomy, beneficence, non-maleficence, and justice.

The authors fail to establish any hierarchical character between these principles and claim that conflicts require case-by-case analyses. However, the utilitarians' theoretical option (and even Kant's) enables us to recognize that the principles in defense of the individual take precedence over the collective. Beauchamp and Childress evoke Kant: *to violate a person's autonomy is to treat him merely as a means, according to the goals of others, without considering the person's own goals* [17].

The non-maleficence Beauchamp and Childress list is close to the Hippocratic precept *primum non nocere*, from which one learns to not cause harm. The authors understand beneficence (...) *as an action performed for the benefit of the other* (...) *the principle of beneficence refers to the moral obligation to act for the benefit of others* [18].

The conception of justice established by Beauchamp and Childress, in turn, contains elements of different conceptions of justice, such as distributive justice, equitable justice, and fair proportion, which are summarized in the idea that people should be treated equitably. The authors state there is a situation of justice (...) *whenever people are entitled to benefits or burdens due to their properties or particular circumstances, such as the fact that they are productive or have been harmed by another person's acts* [19].

After its systematization, the principlism proposed by Beauchamp and Childress quickly spread throughout the world, as it was recognized as a practical alternative to guide conflicts in the field of health and, in particular, in the conduct of clinical practice. Although it represents an outstanding achievement for humanity and one that cannot be given up, given the complexity of situations and values that involve human life, principlism also proves insufficient in certain circumstances.

Engelhardt states that *people are morally autonomous because they have a self-legislating character* [20] and, as they live in a pluralistic and democratic society marked by a diversity of values, the relationship between people—and, in this case, between physicians and patients—may not be that of moral friends, who share the same scale of values but that of moral strangers.

However, via the plurality and diversity of values which permeate the contemporary world, the mere following of the bases proposed by principlism often fails to make the act virtuous. The diversity of values requires healthcare providers to be able to ask themselves: "although the orientation of the principlist model is this, in this situation, how can I be virtuous for the good of patients? Should I follow the norm or should I violate the guidance to achieve patients' good?

Unlike the principlist model, which contains an obligation to follow principles, Kant [15] considered

that a true moral engine was not acting out of obligation to the law but out of one's own will, which he called acting out of good will. On the other hand, it is not this philosophical approach to acting out of duty that motivates the idea of legal and medical ethics since, for jurists, the unfulfilled duty fails to imply a philosophical, moral sanction but penal coercion.

This differentiation is striking, as society is still based on the idea that all moral action is linked to the binomial right/duty. The consequence of the act, that is, acting correctly (in this case, per the law), fails to depend on individuals' values or choices. It will occur via an ethical standardization above individual opinion, no longer autonomous but heteronomous.

The Code of Medical Ethics

The new CEM (Resolution CFM 2,217/2018) [1] added a new fundamental principle. it contains, in total, 26 fundamental principles, with 11 norms defining physicians' rights when exercising their profession. All 117 articles begin with the expression. "physicians are forbidden," which refers to a negative moral standardization in which prohibiting is close to "not allowing." Thus, as in many other codes of conduct, the negative is more prominent than the positive.

According to Dall'Agnol, this semantic detail is due to (...) *an action that takes place "not" as a direct consequence of the beliefs and norms subordinated to the active subject (in this case, the physician), but instead acting coordinated by rules, law, or norms external to the subject. In other words, a deontological ethical action in which one acts not out of personal or internal conviction but out of respect for rules external to the individual. Here, one could infer a right action within the law due to a legal obligation and fear of penalty. An action not supported by convictions but by fear of coercion. Not for autonomy but for heteronomy* [21].

Thus, in conclusion, the CEM, in line with its objective of regulating, proposes to be a code of deontological and heteronomous conduct. In this sense, the CEM does not differ from codes of other professions, fulfilling something much more coercive and prohibitive than educational.

However, this reflection returns in this aspect, that is, it is not a matter of diminishing the importance of CEM or even questioning its validity. Instead, for the code to be fulfilled virtuously and not as a mere formal instrument, physicians must also be trained in virtue ethics. In other words, if the CEM presents itself as a standard which brings many prohibitions (that is, as something heteronomous), the ethics of virtues enables acting to be based on the idea that it is better to act this way because it is better for the good of patients. In other words, there are two perspectives: one prohibitive, with a negative character and another positive, which meets the mission of medicine itself.

Foundations of virtue ethics

This section intends to show how virtue ethics can guide the deontological conduct of healthcare providers both in their training and practice, so that decisions, although still made based on the deontology of codes, are the most virtuous possible. Thus, given the diversity of values and moral pluralism of current times, in addition to fulfilling the duties of deontology, it is also necessary to consider each individual's universe of values. Thus, the good done should not be understood as the fulfillment of the duty of deontology but rather as a moral duty of the profession.

Although the virtue ethics proposed by Aristotle neither defended equality between people, prevented moral virtuosity from being taught by habit and for all nor from being improved and learned [12]. The philosopher affirmed that only a virtuous life could make the individual happy. In establishing the distinction between intellectual and moral virtues, Aristotle states that the former is taught while the latter is acquired by habit [22].

When problematizing the ethics of virtues for medicine, Pellegrino and Thomasma claim that the ethics of virtues is more necessary to medicine than deontological ethics. According to the authors, [medicine] *is itself an exercise in practical wisdom—a correct way of acting, in complex and uncertain circumstances, in pursuit of a specific end, that is, the good of a particular person who is sick. It is when choosing a good and right*

action becomes difficult, when the temptations of self-interest are strongest, when unexpected nuances of good and evil arise, and when no one is looking that the differences between a virtue-based ethic and a law-and/or-duty-based ethics can be clearly distinguished [23].

Concerning the four principles proposed by Beauchamp and Childress, Pellegrino and Thomasma [23] oppose the idea that their principles lie in a horizontal hierarchy and establish beneficence as the first and greatest principle. The authors maintain that only by following beneficence will the most significant end of the medical profession be reached, that is, to do good. According to them, beneficence has levels, which can be understood as much more than non-maleficence.

For the authors, *beneficence is the ethical principle that encourages physicians to activate their moral commitments and personal support to patients instead of only respecting their rights* [24]. They also state that, although virtues have no value in themselves, they have instrumental value, for the most virtuous physicians will better follow the rules.

Reinforcing this idea, Petry states that, (...) *however, it can be argued that the virtues in principlism not only reinforce the practice based on principles but often constitute the condition for their correct application given the variety of circumstances which may occur. Since these principles are unable to provide a clear guideline to be followed, it is up to the agent to judge what should be done. For example, the virtue of discernment would be necessary in this case* [25].

In their study, Pellegrino and Thomasma [23] offer a better solution to the debate between Kantianism and utilitarianism, stating that the primary value in medicine is patients' good and that deontological or utilitarian tradition fails to fully represent this. Opposing the Kantian tradition and its election of the supremacy of autonomy, the authors emphasize that, despite agreeing that freedom is essential in a pluralistic society, this cannot be seen as a significant condition of morality.

When dealing with the concept of autonomy, the authors state that, for Aristotle, ethics is part of politics. Furthermore, autonomy is like a gift given from one to the other with a view to the common good. Thus, *autonomy imposes on us at least two obligations: use our freedom in determining what we should do and use our freedom to promote social good and maximize the good of our peers* [26].

When dealing with beneficence based on trust, Pellegrino and Thomasma point out that there is a fiduciary contract in physician-patient relationships based exclusively on trust and reinforce that *ethics of rules does not guarantee that its rules will be enforced* [27]. Trust must emerge of beneficence. Only in a relationship thus supported in beneficence, both physicians and patients maintain trust with each other in the pursuit of the best interests arising from this relationship.

When dealing with the good, Pellegrino and Thomasma [23] reinforce the idea that patients' good is the primordial and oldest motor associated with medicine. Furthermore, when defining what patients' good is, the authors resort to the Aristotelian tradition, according to which the good is intrinsic to good things, and these, in turn, should foster the aggrandizement of the human being. Furthermore, although good can acquire different meanings on the part of the patient, good is what he seeks to possess and, on the part of the physician, it means fulfilling their duty to always do the best for patients.

Thus, benevolence-generating good fundamentally differs from the paternalistic benevolence tied to Hippocrates. According to Pellegrino and Thomasma [23], the medical professional must seek not only what can be called medical good but also patients' good. Thus, it is evident that contemporary benevolence considers that the good measured by physicians' attitude in technically acting in search for a cure must be complemented by understanding patients' good, considering their interests and, above all, their beliefs and scale of values.

The authors [23] state that the supreme good must be the starting point of a person's moral reasoning and this good is composed of four components. They are, in descending order: 1) the ultimate good, the *télos* of life, as conceived by the patient; 2) the good that is based on the patient's ability to reason and choose; 3) the best interests of the patient; and 4) the biomedical or clinical good [23].

Pellegrino and Thomasma distinguish benevolence from beneficence when dealing with a good medical professional. For the authors, benevolence consists of desiring the patient's good, whereas beneficence is doing good. Thus, a person doing what is right and good relates doing good to respect for the inherent rights of another human being and to the recognition of duties and obligations. The authors reinforce that only physicians' virtue would be a definitive guarantee that patients' good will be respected and desired [23].

Thus, a virtuous physician is confidently expected to profess what is right and the good intrinsic to his practice since virtue is linked to the willingness to do good, which is the ultimate aim of medicine. In contrast to those who argue that the true good for the patient is limited to the correct application of medical knowledge, the authors point out that *the immediate end of medicine is not simply proficient technical performance but the use of this performance to achieve a good end, the good of the patient* [28]. It is the good of patients which contemplates their life project, their beliefs, their values, and their worldview.

The need for virtue ethics is recognized by Beauchamp and Childress [17] when they offer the bases of principlism. For the authors, without ethics of virtues, there is greater difficulty in reaching the *télos* of biomedical activities of doing good. Furthermore, the authors add that only by acting to pursue the good will the subject follow norms given by some deontology.

Thus, being virtuous does not mean acting based on virtue as understood by the Greeks, but rather recognizing that the patient is the bearer of morality, a worldview, and values that need to be respected. Alternatively, in the words of Beauchamp and Childress: *morality, without character traits, emotional reactions, and ideals greater than principles and rules, would be cold and unenthusiastic* [29].

The complexity of interests and situations involving the physician-patient relationship makes some physicians adopt certain measures of caution via documents jointly signed by both parties, which became known as defensive medicine. Faced with this reality, Beauchamp and Childress propose the concept of moral integrity, attributing to it the meaning of firmness, reliability, completeness, and integration of moral character. For them, moral integrity is *a character trait of coherent integration of justifiable moral values and fidelity to them in judgments and actions. A vital aspect of it is fidelity to basic norms of obligation* [30].

The virtues, ponder the authors [17], establish expectations for any worthy human relationship. However, in contemporary times, moral excellence is nothing more than a hobby or other project concerning the agent himself as society has moved away from the Aristotelian guideline of an admirable life for moral fulfillment.

Final considerations

Upon reaching the end of this reflection, which sought to analyze how ethics of virtues can contribute to physicians using the CEM in a virtuous way, with a view to the good of patients and not only as a legal instrument to defend the physicians, our conclusion is that the lack of academic and continuing education for physicians, related to the world of values, makes these professionals unable to assess the essence of their profession and, consequently, of their actions.

The logic of today's society is based on what can be called the era of rights. Thus, if in medical history, patients had no rights since physicians were the ones who held the technical, scientific, moral, and religious knowledge, patients currently have the right to be adequately informed and clarified about their illnesses, choose the treatment to which they want to be subjected and, to be respected for their religiosity and the scale of values guiding their life.

These two contexts, that is, inadequate medical training in the world of values and the era of patients' rights, generate conflicting situations and distrust in physician-patient relationships. On the part of physicians, there is the fear that their patients will sue them legally for some procedure they judged as inappropriate. Patients fear that physicians have failed to act seeking their good but personal, economic, or even institutional interests. The CEM was created to address this mistrust to emphasize the mission of medicine and protect patients. In practice, however, the CEM has been used more as an instrument of legal protection for physicians than patients.

Therefore, the CEM ended up reinforcing the idea, present in medicine, that virtuous action depends on following rules and norms as something heteronomous without any reference to the individual values of professionals. Thus, given the complexity involved in the world of current values, a complexity that is manifested in each patient, in conclusion, the blind obedience of medical providers to the CEM can represent an immoral attitude which opposes the ideals and mission of medicine, although it may be legal.

This study aims neither to diminish the need for and importance of CEM nor propose a review of its principles and norms or its suspension but rather to emphasize that its use will only be virtuous if the providers who use the code are also virtuous. Thus, virtue ethics represents a complementarity, not an opposition.

In *Foundations of Bioethics*, Gracia entitles his epilogue "The Perfect Physician," stating that *physicians only become "good" and "perfect" when they have converted their technical virtuosity and moral virtue into a kind of second nature, in a way of life. Perfect physicians are virtuous physicians* [31].

In another context, when testifying to his work as a professor of a medical course, Gracia states that, by encouraging his students to search for the intrinsic value of things, experience has shown that they *discover a new world, fundamental things not only for their professional activity but for their life. A transformation takes place in them that cannot be forgotten* [32].

The challenge, therefore, is not to improve the code but to offer qualified training in the world of values, both in academic and continuing education, to all physicians so they can achieve the moral excellence of their profession and can thus deliberate to consider the good of patients. The acquisition of moral excellence will make them not only good but also kind physicians.

Update

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