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The Problematic Virtue of Physician Exceptionalism

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2017

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## Abstract

### The Problematic Virtue of Physician Exceptionalism

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This thesis looks specifically at virtues within the medical community, focusing on the virtue of physician exceptionalism as an example of a problematic virtue. Taking Alasdair MacIntyre's point on virtue ethics and bioethicist Edmund Pellegrino's own interpretation as it pertains to medicine as initial grounding points, this thesis seeks to unpack how a virtue could be problematic in essence. Within medical education, the virtue of physician exceptionalism is internalized, reinforced, and inherited through subtler avenues such as through medical school's hidden curriculum. Ultimately, physician exceptionalism is a problematic virtue because it leads to the distortion of physician self-image as it relates to physician psychological distress, seen starkly in the high rates of depression, anxiety, suicide attempts, and suicide completion. As a virtue, physician exceptionalism contributes to certain goals of medicine, yet is problematic in the way it negatively affects its practitioners. Fundamentally, the nature of something as oxymoronic as a 'problematic virtue' as a distinct and separate category has larger, philosophical implications in how we approach, understand, and converse about the virtues in our everyday life and society.

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## Introduction

“I kept wondering why no one helped [my son]. How did I miss all the signs? Somehow, he must have been wanting to reach out but was too proud to admit to what would be viewed as a failure. God forbid, doctors cannot be losers.”

-Aida<sup>1</sup>

“I attended Harvard Medical School, made what the books assured me was a reliable suicide attempt, woke up thirty-six hours later. Blind luck.”

-Glenn, M.D. <sup>1</sup>

An internist overdoses. A family doctor shoots himself in the head. A medical student jumps to her death.

There is an air of tragic irony associated with the idea that those who devote their entire lives to healing others sometime end up taking their own lives instead. A single suicide is heartbreaking. A handful of suicides is terrible—but perhaps even then is viewed as statistically inevitable. However, when hundreds of physicians across the nation end up taking their own lives each year, the numbers alone must be enough to lend pause and lead us to question why.

Within the past few decades, there has been significant talk about various crises in medicine. Physicians have expressed frustration over shorter patient interaction time while others have claimed that medicine has gotten drastically less humanistic. In an interview given in 2016, US Surgeon General Vivek Murthy expressed concern over physician suicide and burnout rates. And in the latter half of the twentieth century, American bioethicist Edmund Pellegrino wrote extensively on what he perceived were threats to medicine.

It would be shortsighted to not include Pellegrino in a discussion on the philosophy of medicine and medical virtues given that Pellegrino, himself a practicing physician and an academic, wrote extensively on ethics, philosophy, and medical virtues. Writing around the 1970s, Pellegrino specifically highlighted the influential role that rising business motives, pharmaceutical profits, and insurance companies had in transforming physicians into business practitioners. Specifically, Pellegrino criticized instances of fiscally-charged conflicts of interest and the leveraging of healthcare access to those who have certain financial means. These threats, according to Pellegrino, contribute to the “moral malaise” in medicine (Pellegrino and Thomasma 1993)<sup>1</sup>.

Pellegrino’s own account of medicine borrows heavily from Alasdair MacIntyre’s virtue ethics, adopting the idea that virtues are intricately bound up with their social and practical context. His further writings on medicine as a community included the idea that physicians hold themselves to certain virtues that are necessary in medicine. Going off of that idea, then, allowed for Pellegrino to place his diagnosis on individual physician culpability, specifically attributing the crisis in healthcare to a decay in physician moral alignment and their deviation from these virtues in medicine. Specifically, keeping in mind the type of threats Pellegrino was writing about, these physicians allow for their own economic self-interest to override the altruism owed to the patient.

But we must ask if that was the correct diagnosis—or, at the very least, a complete diagnosis. By Pellegrino and MacIntyre’s account of the origin of virtues, if good virtues arise within communities, it is also possible that problematic virtues, however oxymoronic in nature,

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<sup>1</sup> Edmund D. Pellegrino, M.D., and David C. Thomasma, Ph.D., are co-authors for *The Virtues in Medical Practice*. Citations for the remainder of this thesis will include both names.

could also exist. Though there have been instances of what can only be called failures in virtue alignment, this thesis looks not at individual failings, but rather, at the nature of the virtues themselves. Specifically, what kinds of virtues are encouraged and cultivated in a space such as medicine? And what happens if there is something dangerous about a virtue in question—in short, what might be an example of a problematic virtue in medicine? Taking the virtue of physician exceptionalism as a point for inquiry, this thesis seeks to explore how it arises within medicine and what makes it problematic in the first place.

This thesis does not seek to equate the problem of physician suicide to the problem of pharmaceutical influence, nor does it seek to defend virtue ethics as the sole descriptor of medicine. However, this thesis does seek to explore what the nature of a problematic virtue might entail, specifically looking at how it shows up in medicine and its subsequent consequences, using the virtue of physician exceptionalism as orientation for this discussion.

Part I will give a short overview of virtue ethics, linking up MacIntyre's premises with Pellegrino's own understanding of virtues. This background will ground the jump to physician exceptionalism as a virtue. Part II will look at how the virtue of physician exceptionalism is found within Pellegrino's understanding of medicine as a community and how it is reproduced through subtle avenues in medical education. The second part will also link the virtue of physician exceptionalism to physician psychological distress, focusing specifically on completed suicide rates. And finally, in Part III, this thesis will look at what makes physician exceptionalism a problematic virtue within medicine. Additionally, concluding remarks will address possible limitations of virtue ethics and the larger, philosophical implications that come with problematic virtues existing as its own separate category.

## **I. Virtues in the medical community**

### ***Alasdair MacIntyre and virtues***

Since the thesis is, essentially, a conversation on virtues as situated within medicine, it is important to clarify a few points regarding the nature of virtues as they will be discussed within this thesis. This thesis does not seek to give its own definition of a virtue. Since much of the grounding is extracted from MacIntyre's own work on virtues and Pellegrino's interpretation of it, this thesis will instead borrow an account of virtues based on these two authors. MacIntyre's own definition of a virtue, for which this thesis consequentially adopts, is "an acquired human quality, the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods" (MacIntyre 1984). Additionally, it is important to note that virtues are also grounded within its social context, a point that MacIntyre recognizes and uses Homeric society to exemplify.

As part of his historical analysis, MacIntyre details a brief, but necessary, account of the virtues as they existed in the heroic societies. This thesis does not argue that medical culture is entirely equivalent to heroic cultures. However, just as MacIntyre recognized that classical society and its successors are not exactly synonymous with the heroic societies, there exist certain character traits of heroic societies that allow us a fuller understanding of contemporary society and their orientation to virtues (MacIntyre 1984). Recognizing MacIntyre's main points—(a) the importance of social structure as essential grounding for virtues and (b) virtues as a historic tradition—are pertinent and necessary for a conversation on virtues within the medical community.

An important aspect of Homeric society was its combination of social role and identity. As MacIntyre claimed, “Any adequate account of the virtues in heroic society would be impossible which divorced them from their context in its social structure” (MacIntyre 1984). The same thought process can be overlapped with virtues upheld within the medical community, a main point found in Pellegrino’s own account of virtues in medicine. For medicine, then, it is not enough to simply look at the important virtues in a vacuum; they are necessarily grounded in its social structure.

Additionally, it is also vital to recognize that our understanding and possession of virtues are part of a tradition. Virtues, as MacIntyre conceives of them, do not spontaneously arise and are not reborn time and time again after societies rise and fall. Rather, the virtues that we hold claim to—and the ones we do not—exist because certain ones have been inherited over time (MacIntyre 1984). Medicine, too, is as historically salient and recognizable as the larger contemporary society, with medical culture also existing as a site for the reproduction, perpetuation, and inheritance of certain virtues. Understanding that the virtues found within medical culture have a historical legacy is significant for further understanding of not only what virtues exist, but their reason for inheritance and their purpose within medical culture.

In overlapping MacIntyre’s conception of virtues onto Pellegrino’s, it is important to understand that their definitions of virtue are not dissimilar. Pellegrino, like MacIntyre, recognizes how virtues arise out of its social context and are instrumental to the goals of the community, specifically defining virtues as those that make for a “good” physician, one who is dedicated to the healing ends of medicine (Pellegrino and Thomasma 1993). This definition of virtues is important in further conversations surrounding medicine as a moral community.

### ***Pellegrino on medicine as a moral community***

According to Pellegrino, medicine exists as a community, a group of individuals<sup>2</sup> committed to healing and to the ends of medicine. And as a community, its relation to the virtues that it sustains and embodies is critical. However, it is not enough to remark that medicine is just a community. Rather, Pellegrino argues that medicine cannot escape being a *moral* community because certain aspects, unique to medicine, confer a particular type and degree of collective responsibility onto its practitioners. These responsibilities are necessarily moral in nature because it holds the physicians—who are, by their existence within a moral community, seen as moral agents—accountable in their relationality to their patients. According to Pellegrino, the three premises that ground medicine as a moral community are the nature of illness, the nonproprietary nature of medical knowledge, and the nature and circumstances of a professional oath (Pellegrino and Thomasma 1993).

Briefly, illness confers a certain degree of vulnerability on behalf of the ill patient and, therefore, a certain degree of responsibility to heal on behalf of the practicing physician. This dependent relationship, brought out by the nature of illness, mandates a certain degree of trust that the physician will use their medical knowledge for healing and not for harm. Secondly, the nonproprietary nature of medical knowledge promotes physician supply for societal demand. Medical knowledge is not private property, according to Pellegrino, and is supposed to be utilized as a tool for healing. To withhold this knowledge would be unethical. And finally, a professional oath is a symbolic and public promise that physicians will utilize their medical training for the

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<sup>2</sup> The question of demarcating who and what is part of the medical community, though worthy of discussion, is outside the scope of this thesis.

good of the patient, “to generate a strong moral bond and a collective responsibility” (Pellegrino and Thomasma 1993). Taking MacIntyre’s point on the relationship between community and virtues, these three premises shape both the moral community and its subsequent virtues. And as these virtues are shaped in the community, their impact upon moral agents is not insignificant.

### ***The virtue of physician exceptionalism***

What might a virtue of physician exceptionalism mean, much like look like in practice? And how might it be problematic? The definition of exceptionalism is tricky to untangle, examples of which include the politically charged term of ‘American exceptionalism’ that has historically been used to describe the uniqueness of America’s ideology and government (De Tocqueville 1835); anthropocentrism (also known as human exceptionalism) as the belief in the uniqueness and superiority of humans; and, in cases of disease, such as HIV-exceptionalism, which promotes the idea that HIV/AIDS should be treated differently from other diseases (Bayer 1991). These examples give an idea of what physician exceptionalism might contain and look like in practice.

*Physician* exceptionalism is not a broadly used term, though, with few mentions of it explicitly in literature (Onyura and Leslie 2016). However, loosely defined, physician exceptionalism is the mentality that physicians are, unlike their patients or their non-physician peers, resistant to illness<sup>3</sup>. Physician exceptionalism allows for physicians to hold themselves to higher standards of success, strength, and stability, possessing qualities that either exceed the qualities found in non-physician bodies or that exceed what is even sustainably possible.

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<sup>3</sup> It is interesting to note here that there are entire studies and novels dedicated to the experience of doctors becoming ill and of their perspective once roles are reversed. This suggests that physicians’ experiences with confronting disease in their patients change the way they view disease once they themselves are afflicted.

Physicians may also hold the belief that they can withstand and be subjected to more than their non-physician peers, and should do so without complaint or perceived “weakness”.

Pellegrino, in talking about the virtues in medical practice, often cites compassion, justice, and phronesis as examples of ideal virtues (Pellegrino and Thomasma 1993). To Pellegrino, these virtues allow for a “good” physician. Without delving too deeply into a conversation surrounding normative labels, those virtues can be seen as positive and are explicitly encouraged within the community by being openly talked about and actively promoted in places such as physician training, biomedical ethics, and healthcare practice (Pellegrino and Thomasma 1993, Beauchamp 2007). However, referencing once again MacIntyre’s point about the importance of social context, if the medical community could encourage positive virtues, it could also bring about and reinforce problematic virtues, such as physician exceptionalism, albeit through more hidden, implicit ways.

The very notion of a ‘problematic virtue’ is curiously paradoxical in nature. By Aristotelian standards, the connotation of a virtue orienting one to be a ‘good’ person is positive in understanding. So, therefore, how can a virtue be problematic? If we once again apply MacIntyre’s point of virtues resulting from their social context, we can understand that there may be instances whereby virtues arise, exist, and persist in ways that are either detrimental or deeply distorting to the community. These virtues, though distorting, are maintained because, to some degree, it is needed in the community. Pellegrino, in his own critique of the moral community, acknowledges and even provides an example of a ‘problematic virtue’.

Pellegrino, when he addresses the significant tension between self-interest and altruism, claims, “For the first time in medical history, self-interest has been given legal and moral legitimation and profit has been turned into a professional virtue” (Pellegrino and Thomasma



1993). His sweeping generalization of it being the first time in history notwithstanding, this statement brings up three important points in approaching the paradoxical air surrounding the virtue of exceptionalism: that (a) the virtue as a whole, and not as the extremes, is problematic, that (b) certain traits, though problematic to the community in question, can be held up as virtues nonetheless, and that (c) problematic virtues are sustained within the community because they, in part, confer a certain degree of advantage for the community and its goals.

It is important here to think about different ways a virtue can be problematic. Are they, as Aristotle conceived of them, problematic at their extremes? If that were the case, the remainder of this thesis would be dedicated to sorting through representatives of the extremes, going back and forth until a happy equilibrium were reached. Or, perhaps, could the virtue *in essence* be problematic? If the latter were to be argued, as this thesis seeks to do, the virtue itself would have to be distorting to the community at hand.

Pellegrino's own example of a problematic virtue makes it easier to set up the virtue of exceptionalism following similar lines of logic. According to Pellegrino, profit as a virtue originates from the social context and is also oxymoronic in nature. Even though Pellegrino doesn't explicitly add a normative judgment on profit as necessarily a bad virtue, when he decries profit turning physicians into business people and muddying the waters of what it means to be a physician, it can be intuited that profit as a newfound virtue is especially damaging to medicine as a moral community.

The examples of exceptionalism and profit as both problematic virtues both converge and diverge. It is worth noting that Pellegrino does not talk about profit as on a spectrum bookended by negative extremes. Rather, his statement on profit as a virtue, though short, allows for the

interpretation that the problematic nature of a virtue arises out of its essence and not from its extremes. Moreover, it is worth looking at the third point as it relates to the maintenance of virtues within a community. Profit as a virtue is sustained in part because the social and economic pressures at the time incentivize its conservation. For virtues to not just exist but to persist, they must, even if distortingly, contribute to the goal of the community. If we accept the notion that the economic external forces at the time transformed the goal of medicine to one oriented toward profit maximization, it is intuitive why profit, then, would be sustained as a virtue within the community.

The virtue of physician exceptionalism, on the contrary, and as this thesis outlines, originates not externally, but is rather built and reproduced internally. Particularly, physician exceptionalism as a problematic virtue arises through nuanced historical narratives about the role of the physician, concepts of the “good” physician, and traditional understandings of medical virtues (Drane 1988, Pellegrino and Thomasma 1993). These ideas, sustained in existence by institutional structures and messy narratives, can consequentially become internalized, bred, and reproduced within physician mentalities. As it will be shown, the virtue of exceptionalism poses similar threats to the ends of the healing relationship, yet is also maintained because it paradoxically also contributes to the goals of the community. The virtue of exceptionalism, consequentially, has no insignificant role in contributing to physician distress, seen starkly through instances of depression, anxiety, suicide attempts, and suicide completion.

## **II. On the virtue of exceptionalism as found and perpetuated within the medical community**

### ***Virtue of physician exceptionalism as inherent within Pellegrino's moral community***

Physician exceptionalism—even without that explicit label—is not novel, as traces of it can be found within the historical narratives of medicine as a community. As Pellegrino points out when talking about medicine's historical antecedents, though physician and medical models have changed throughout history, there are certain key elements that have been sustained, persisting “in remnant form in modern collective professional consciousness” (Pellegrino and Thomasma 1993). The oldest model of a medical community and physician attitude, encouraged by lines in the Hippocratic Oath, exhibits undertones of exceptionalism, encouraging the idea that “physicians have certain responsibilities that set them apart from society” and that “they see themselves as a privileged group” (Pellegrino and Thomasma 1993).

In searching for traces of physician exceptionalism, the most obvious first step is using Pellegrino's understanding of the medical community as a site for internal excavation. Since Pellegrino posits that the moral community is grounded in the three premises of illness, knowledge, and public promise, these points guide our understanding of the nature of exceptionalism as it exists internally to the community.

The first, built on the nature of illness, establishes the physician as a healer. The concept of physician bodies as healing bodies is laudable, but is problematic because in practice it encourages them to see themselves as transcending into a realm of being solely healers (May 1977). It is important, here, to note that physicians become physicians by a process of socialization. The varying degrees and kinds of physician socialization have been well-documented, but in-depth elaboration into the details are beyond the scope of this thesis

(Merton, Reader et al. 1957, Becker, Geer et al. 1962, Good 1995, Brainard and Brislen 2007). In these cases, the entirety of a physician's identity as a professional is wrapped up in the concept of equating oneself to only a healer: "A professional [who] eats to heal, drives to heal, reads to heal, comforts to heal, rebukes to heal, and rests to heal" (Lammers and Verhey 1998). The idea that a physician's role is so densely tied in with the concept of healing a patient becomes problematic when, by setting up this mentality, it reinforces the idea that healing a patient is the sole end of the profession, even if it were to come at the cost of the physician.

The secondary premise can be seen as inherently problematic and possibly even hypocritical in practice. Though Pellegrino claims that the physician's knowledge is not proprietary, it is later claimed that "doctors, through licensing, credentialing, and certification, are promised a monopoly by society over the usual medical knowledge" (Pellegrino and Thomasma 1993). Despite the knowledge not being private property as it is traditionally understood, there is a propriety that exists within the collective medical community that is inaccessible to those external to the community. Consequentially, there is power and recognition in who has access to this body of medical knowledge and who decides how it should be utilized. The very idea that a group should hold a monopoly over a body of knowledge allows for movement into a realm that is separate from groups that do not.

Finally, the concept of oath-taking as a form of public promise also showcases shadows of exceptionalism. As Pellegrino explains, the act of oath-taking is "a public promise...that the new physician understands the gravity of his or her calling, promises to be competent, and promises to use that competence in the interests of the sick." To find the grains of physician exceptionalism, the implications and intrinsic notions of a public promise must be unraveled. "Some effacement

of self-interest is thus intrinsic to every medical oath,” states Pellegrino. “That is what makes medicine truly a profession” (Pellegrino and Thomasma 1993). This description of what a public promise entails implies that the physician has now, publicly and explicitly, promised to sacrifice their own interests for the wellbeing of their patients. Though Pellegrino talks about self-interest as purely economic in nature, the message that is sent through public oath-taking easily bleeds past just being solely economic.

If we accept the idea that physician exceptionalism is a problematic virtue that is encouraged from inside the medical community, it might be worthwhile to look at how social, political, and economic forces operate not externally internal to the community. A greater understanding of medicine, placed within the context of reality—which has unavoidable and deeply tangled ties with social, political, and economic currents—will better contribute to not only understanding physicians as virtuous moral agents and medicine as a moral community, but will allow for the grounds of critique that Pellegrino ultimately misses.

### ***The implicit reinforcement of physician exceptionalism***

How can something as problematic as the virtue of physician exceptionalism exist, and how does it sustained? MacIntyre’s earlier point on virtues as being part of a tradition is important to address here, as it gives us insight into the reproduction and cyclic nature of these virtues found within medicine. As medicine is a body of knowledge and a community of professionals, the gatekeeper to this community is found in its educational pathway. As such, if we accept the notion that the virtue of physician exceptionalism exists, then it could be continuously reproduced by medical education.

It has been recognized that medical education—like most institutions—is marked by the visibility and invisibility of its practices. The visible aspects come in the form of the formal curriculum, which manifests itself in course offerings, lecture series, and lab involvement, to name a few. The formal curriculum ends up influencing biomedical knowledge and technical skill attainment for students. However, there is a less visible arm of medical education that has just as powerful an influence, if not more, on medical school students. This covert curriculum is the “hidden curriculum”, dubbed in part because of the inherent ways that it seeks to introduce and reproduce certain values throughout medical culture (Hafferty and Franks 1994, Hafferty 1998).

The hidden curriculum operates in unseen, concealed ways, often through interpersonal modeling and in the values that are invisibly conferred by way of institutional organization. For instance, in a testament to the power of modeling, residential interns will be more shaped by their attending’s interactions with patients and colleagues than by formalized ways of acting learned in classroom settings. This implicit message ends up inverting the traditional message of “Do as I say, not as I do” (Konner 1987, Jaye, Egan et al. 2006).

One might think that virtues can only be cultivated by explicit endorsement by the community. However, if the influence of the hidden curriculum is any indication, the community in question can also cultivate virtues through implicit ways. Looking critically at medical education and socialization as a point of reproduction (necessary for understanding virtues as part of a tradition, much to MacIntyre’s point), the hidden curriculum can be used as a microscope to dissect the ways in which physician exceptionalism has shown up and the almost sinister ways in which it has been cyclically inherited.

Early whiffs of physician exceptionalism (citations back to Hippocrates notwithstanding), as but one example, can be found in the works and essays of William Osler, founder of the first medical residency program at Johns Hopkins. In his famous essay, *Aequanimitas*, Osler extolled imperturbability in physicians as an “essential, bodily virtue”, one that is characterized by “coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of grave peril, immobility, impassiveness” (Osler 1910).

Though Osler’s concept of imperturbability was meant to assist the physician in delivering efficient patient care under trying circumstances, it can also be interpreted to mean that physicians, at all times, must hold themselves to a certain degree of toughness that is not expected of their non-physician peers. The concept of imperturbability might even imbue physicians with a sense that they constantly need to hold themselves to degrees of emotional, intellectual, and physical competence that may not even be possible in the first place.

Though imperturbability as coated physician exceptionalism has explicitly disappeared over time, the virtue itself is sustained, again in essence, through the process of medical socialization and the hidden curriculum. In that way, though never appearing in medical school mission statements, exceptionalism is imposed and normalized as a part of what it means to be a doctor. To best see this in practice is to refer to specific instances in which exceptionalistic standards are imposed and exceptionalism is peddled as a virtue.

In his ethnography of medical education, anthropologist Melvin Konner details his experience with medical school, specifically highlighting the socialization that is most clearly seen and felt during the third year. The fine details of his experience are too expansive for the confines

of this thesis, but the points that are most salient to this discussion are that (a) exceptionalism is used as a form of justification and that (b) exceptionalism is inherent to physician ontology.

For one, the tradition of “education by humiliation” has been evident in medical education, with attending physicians using disrespect, intimidation, and bullying as pedagogical tools (Leape, Shore et al. 2012). The culture of medical student abuse (both physical and verbal) has been long-recognized and documented, even if it has resulted in a lack of significant amelioration (Silver and Glick 1990, Kassebaum and Cutler 1998, Chen 2012). As but another example, interns are subjected to working continuously long hours as part of their training, facilitated in no small part by residency work hours and the underreporting of the true amount of time spent on shift due to biases in self-reporting (Carroll 2016). This is simply just part of the medical educational tradition—and so it goes.

But, as Konner asks, why should it be like this? One hypothesis “argues that stress and sleeplessness are essential in the making of a doctor. He characterizes the barrier between the physician-in-training and the acts he or she must eventually perform as not merely formidable but insurmountable. No normal person can cross it; no normal person can assume such responsibility...so the person must be temporarily rendered abnormal” (Konner 1987). Perhaps, then, the exceptionalistic standards that physicians are subjected to and the exceptionalistic standards that physicians hold themselves to are used as grounds for justification.

The stress, the sleeplessness, and the alexithymia is the price to pay for this profession. “Because we view it as painful, stressful, life-distorting, and terribly long, we allow it to justify the remarkable power we give the doctor over us,” remarks Konner. “The doctor has paid for the power with suffering” (Konner 1987). But all of these experiences are also more than just a



price—because of the way it has been normalized and ingrained within medical culture, it's not too radical to claim that it is also seen as an indisputable and inextricable part of physician ontology.

### ***Current climate of physician psychological distress***

Physician distress is a public health issue, given that the physician suicide rate is higher than rates of suicide in the general population (Gold, Sen et al. 2013) and in other academic groups (Tyssen, Røvik et al. 2004), with the current estimated rate hovering around 400 deaths/year (Center, Davis et al. 2003). Mental health concerns, highlighting, specifically, cases of depression and anxiety, have been documented heavily, with studies showcasing high rates of these mental health comorbidities within medical school students (Dyrbye, Thomas et al. 2005, Goldman, Shah et al. 2015) and practicing physicians (Gold, Sen et al. 2013). Other studies show that the gap in suicide rates begin as early as medical school, with suicide completion rates being higher in women than in men (Schernhammer and Colditz 2004). And though outside the bounds of this thesis, it is also pertinent to note that physicians are more prone to abuse prescription drugs, such as benzodiazepines and opiates, citing self-prescription in many of these cases (Hughes, Brandenburg et al. 1992).

Other studies have also documented probable factors contributing to overall physician distress. Dyrbye et al., in their systematic review, cited academic pressure, workload, financial concerns, sleep deprivation, and exposure to patients' suffering and deaths as significant influences to the detriment of physician wellbeing (Dyrbye, Thomas et al. 2006). While noteworthy, exploration and analysis into these factors are beyond the scope of this thesis. However, there are other significant factors contributing to physician distress that have tie-ins

with medicine's virtue of physician exceptionalism. For one, it has been documented that physicians are characteristically less likely to seek help for their mental illness (Center, Davis et al. 2003). Secondly, hospitals often have punitive approaches that actively deter physicians from seeking help for fear of medical licensure revocation (Miles 1997, Polfliet 2008, Lenzer 2016).

Addressing barriers to help seeking behavior, it is important to acknowledge that mental health stigma is intuitively a contributing obstacle. However, the unique history and prevalence of physician exceptionalism as an inherent aspect of physician ontology also contributes to physicians needing to feel constantly incomparable and that instances of mental illness constitute as "weaknesses". Aforementioned institutional and cultural avenues only reify this internalization. Physicians thus "tend to neglect their own need for psychiatric, emotional, or medical help and are more critical than most people of both others and themselves" (Schernhammer 2005). This, compounded with the highly stigmatized, invisible nature of mental illness, only adds to the distress.

It could be argued that medicine as a profession inherently attracts people who push themselves to these exceptionalistic standards. However, simply viewing physician exceptionalism as an individual character trait would neglect the role, as highlighted earlier, of the institutional context in perpetuating problematic virtues. Here is an important moment to explicitly bring back MacIntyre's point about social contexts shaping and influencing certain values. If medical institutions actively and publicly punish physicians who open up about mental health concerns—as evidenced by residency programs asking applicants to disclose previous or current treatment for mental illness (Polfliet 2008)—it sends the message that physicians should not seek help for illnesses they should not have in the first place. The relationship, here, between

physician internalization of exceptionalism and institutional and cultural messages of exceptionalism is cyclical.

### **III. Analysis and concluding remarks**

#### ***The problematic nature of physician exceptionalism as a virtue***

Before any discussion into the problematic nature of physician exceptionalism as a virtue is to begin, it is necessary to first distinguish the virtue of physician exceptionalism as separate from a vice or a social norm. A vice implies a deviation from what is ideal, perhaps not dissimilar from the moral failings that Pellegrino cited in certain physicians. Conversely, as evidenced throughout this thesis, a virtue is instead upheld by the community as something to strive for or to embody, whether through implicit or explicit avenues. The same line of argument would not apply to a vice. Additionally, a virtue also contributes to certain ends of the community, whereas a vice might actively deter its actualization. Even something like a problematic virtue, though dangerous in some aspects, could contribute in some way to the ends of the community.

Secondly, it is also important to distinguish between a virtue and a social norm. A social norm consists of rules or behaviors that are considered acceptable in any one group or society. The distinguishing factor between a social norm and a virtue ultimately is its orientation toward the ends of the community. It might be a social norm for physicians to shake the hands of their patients when entering the room, but the lack of it would not necessarily impact the ends of medicine. The absence of a virtue, on the other hand, would prevent us from actualizing certain goals in the community.

In the process of unpacking reasons contributing to physician suicide and un-glamorizing medical culture and education, the virtue of exceptionalism needs to be recognized as occupying

no insignificant space within medicine. As an implicit virtue that is adopted not through formal curriculum teachings, but through subtler avenues, physician exceptionalism poses a significant threat to the medical community through its distortion of the physician self.

Since this thesis is largely based on Pellegrino's understanding of medicine, it is important here to use Pellegrino's interpretation as grounds for critiquing exceptionalism's problematic nature. Pellegrino argues that the heart of medicine resides in the healing relationship between physician and patient (Pellegrino and Thomasma 1993). By this line of logic, how would the virtue of exceptionalism be problematic?

The most obvious answer is that physician suicide directly eliminates the healing relationship. If the studies are correct, the average primary care physician has about 2,300 patients under their care<sup>4</sup> (Altschuler, Margolius et al. 2012). With the estimated rate of 400 suicides per year<sup>5</sup>, about a million Americans lose their physicians each year. But to say that the virtue of exceptionalism and physician suicides are detrimental to the medical community because it leaves patients without doctors would be too simple an answer. Rather, the more sinister answer comes not as an elimination of the healing relationship, but as a distortion of it. Exceptionalism as a virtue is problematic because it leads to distortion of the physician self.

The adoption of a virtue of exceptionalism can exacerbate already existing barriers to help-seeking. By the nature of exceptionalistic standards imposed and internalized by physicians, feeling the effects of mental illness could easily be seen as a physician feeling "weak" or "not

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<sup>4</sup>Noting here, of course, that the number of patients vary widely depending on specialty. Exactly which specialty has more patients or has a higher rate of suicide is beyond the scope of this thesis.

<sup>5</sup>This rate of physician suicide in America is most likely underreported due to inaccurate cause of death reporting. No research study has explicitly tried to get a more exact rate.

being able to keep up with the demands of medicine.” Thus, the virtue of exceptionalism can facilitate the physician seeing their suffering as a lack of their own strength or resilience, rather than as a consequence of abusive systemic and institutional practices. The idea that mental health concerns stem from one’s lack of resistance as opposed to abusive institutional and cultural issues can be seen most saliently in hospital wellness programs. In response to growing suicide rates and cases of physician burnout, many hospitals across the nation have adopted physician wellness programs, using tools like meditation and biofeedback therapy as means for stress reduction.

It isn’t to say that these practices are completely ineffective. However, the over-emphasis on galvanizing resilience as opposed to addressing pervasively abusive treatment within medical culture sends the message that these mental health concerns are a result of a lack of resilience with complete disregard for institutional practices that are toxic to physician wellbeing. Even the term “physician burnout” implies a kind of personal fault while discounting institutional culpability. This uptake of exceptionalism can be deeply distorting to a physician’s own sense of themselves—that they see their own struggles with depression, anxiety, and even suicidal thoughts as a manifestation of their shortcomings and failure to meet this imposed and adopted exceptionalistic standard.

Secondly, the sense of physician exceptionalism as a distortive force to the topography of the physician’s concept of self comes when it becomes normalized into medical ontology. It is important here to, briefly, link up the virtue of exceptionalism with the concept of power, specifically, as it exists within medicine. Though the fine details and history of power as it exists specifically within the scope of Westernized biomedicine is more than enough to make for its

own separate paper, this thesis would be incomplete without at least making a small nod to it. There comes a certain type of power associated with internalizing the virtue of exceptionalism—that because physicians are subjected to a degree of exceptionalism that far surpasses what is even feasibly possible, they deserve to claim a certain form of power over their patients. Pellegrino acknowledges, too, this asymmetrical relationship between physician and patient that exists as a result of the patient's dependency and the physician's hold over this kind of power (Pellegrino and Thomasma 1993). This type of power is rarely explicitly acknowledged, but ends up permeating into the many spaces of medicine through, again, certain hidden avenues.

The virtue of exceptionalism is so sinister—pervasive and maintained within medicine—because of how much it has been normalized into both culture and body. Foucault specifically addresses the role normalizing technologies have in the regulation, maintenance, and continual negotiation of power over populations and bodies (Foucault 1990). It is not too far a cry to argue that the existence of physician exceptionalism, then, is used as a way for medicine to maintain control and monopolization over physician bodies. As such, physician exceptionalism succeeds through normalization, as the physicians take up the identity that has been enculturated into them via socialization. In short, the existence of physician exceptionalism functions as a legitimizing and monopolizing force, problematic in both degree and kind.

### ***Concluding remarks and future implications***

The idea of problematic virtues carries implications both within and outside of the medical context. For one, as studies into medical education have shown, there may be more problematic virtues that are cultivated within medicine (Jaye, Egan et al. 2006). Secondly, as a much broader, philosophical question, what might the existence of problematic virtues entail for other

communities? Are all virtues problematic to some degree or kind, or is that qualifier specifically reserved for a separate and distinct category of virtues? If problematic virtues constitute their own separate category, it could have significant consequences on how we approach, understand, and converse about virtues in everyday life and society.

In talking about virtue ethics, it is also important to recognize certain limitations. For one, Pellegrino's foray into individual physician culpability raises questions surrounding individual versus institutional influence and blameworthiness. Perhaps it is no coincidence, then, that many critiques of traditional virtue ethics come from feminist writers, with these critiques often arguing that traditional virtue ethics ignore conditions of oppression that have added, inhibited, and shaped certain character traits (Tessman 2005). Similarly, if the community continuously reinforces certain problematic virtues onto its practitioners, is it really the fault of the individual physician to act one way or another?

Additionally, something that seems to be lacking in traditional virtue ethics is an analysis of power. Since MacIntyre relies so heavily on the social context as grounding for virtues, virtue ethics would be incomplete without at least acknowledging the inherently complex power structures that exist in social institutions. Perhaps, then, it would be interesting to see how a greater understanding of virtue ethics could be accomplished by a better understanding of power dynamics—using Foucauldian discourse analysis, as but one example, as a way to compliment traditional virtue ethics. Ultimately, virtue ethics as a moral theory would be insufficient without at least an analysis into the deeper sociological workings behind how virtues arise in the first place.

Finally, given a conversation on virtues within medicine, it is important to recognize the difference between ideal virtues and actual virtues. Perhaps much of the distortion—and consequent distress—from medicine comes from the sharp discordance between the desired professional virtues and the ones that are actually taught and reinforced in education. As outlined throughout the thesis, oftentimes the internalized virtues are not the ones that are found in an idealized representation of medicine. For as much talk there is of cultivating compassion, integrity, and altruism within physicians (Hafferty 1999, Coulehan and Williams 2001), there is as much, if not more, actual internalization of more problematic virtues such as maleness, fierce competitiveness, and aggression (Jaye, Egan et al. 2006).

So where, exactly, does this leave us with the question of the problematic virtue of physician exceptionalism and problematic virtues in general? Physician exceptionalism, as it has been outlined in this thesis, is problematic in that it distorts a physician's own self-image and can be utilized as a legitimizing force for maintaining control, whether that is in practice or in cases of physician psychological distress. However, one important question that this thesis does not directly answer is whether or not this virtue is necessary to the community. It is interesting that Konner's ethnography and remarks seem to imply that the virtue of exceptionalism plays a significant role in the makings of a doctor, but whether or not it is *necessary* in the makings of a doctor remains to be answered.

Nevertheless, going back to MacIntyre's original definition of virtue, it is important to highlight the latter part of the definition, that "the lack of which effectively prevents us from achieving any such goods" (MacIntyre 1984). Would the nature of the physician-patient relationship change, and would medicine as a community be altered, should such a virtue be



taken out—and would it even be possible in the first place? And in recognizing that 21<sup>st</sup> century medicine is different than medicine in previous times, how would the idea of certain problematic virtues come to affect the way medicine is practiced specifically within our contemporary context? Consequentially, these questions and their answers end up occupying no insignificant space in our continuous discourse on the philosophy of medicine and on its practical implications.

## Notes

1. These quotes are taken from Pamela Wible's book, *Physician Suicide Letters*, a collection of suicide letters and notes confessing depression, anxiety, abuse, and suicide ideation from physicians (Wible 2016). Dr. Wible is an advocate for physician suicide prevention and single-handedly manages a website and phone-line that essentially functions as a physician suicide hotline. Aida's son, Vincent, completed suicide in 1998 while he was a medical resident. Glenn is a physician who left medicine to become a nurse and a teacher due to the toxic medical environment.

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