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Forming Moral Agents in Bioethics Education "after Morality"

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Alasdair MacIntyre's analysis of the conditions of contemporary work in his *Ethics in the Conflicts of Modernity* is, unsurprisingly, descriptive of a U.S. medical system plagued by bureaucracy making it difficult for clinicians to live up to the ideals of their practice.[1] Education in bioethics should respond in ways that prepare a practitioner to safeguard her moral agency and promote the ends of her healing practices. The question an ethics course or training program needs to answer is, "How will this education equip students to be moral agents and to care for patients ethically in the complex settings in which they will work?"

The first task of creating an ethics education program is to understand the kinds of challenges students will face in their future practice. Here I will begin by describing the forces at work in modern medicine. I will then describe the state of typical bioethics education. I will show how bioethics, much like academic philosophy, "marched off in the wrong direction."[2] I will argue that bioethics education is overly focused on principles and quandary ethics, and that an approach to ethics education focused on growing in virtue would be a more effective way to promote ethical practice. To conclude, I will suggest the types of programs in moral formation and ethics training that need to be more prevalent in medical schools and residency programs.

1. A MacIntyrean Diagnosis of the Problem of Contemporary Medicine

Clinicians practice the healing art of medicine within an increasingly complex set of institutional requirements dictating the way they must provide care at the bedside. Among many elements putting pressure on health systems to operate efficiently, the Affordable Care Act (ACA) has emphasized the need to provide high quality, low cost care. In particular, the Values-Based Purchasing Program—whereby federal funding is provided based quality, efficiency, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction surveys, and meaningful use of electronic medical records (EMR)—has necessitated reforms in health care operations over the past decade.[3] Against the background of the litigious culture in the U.S. compelling providers to practice defensive medicine, caregivers are under an enormous amount of pressure. Each of these realities places demands on clinicians that are in addition to the

responsibility of caring for patients. I will give a brief overview of some of the ways the external stressors of practicing medicine today affect clinicians. As they develop curricula, educators need to be mindful of this context.

Unsurprisingly, the extensive reimbursement and compliance-related information that must be documented in the EMR is associated with more time in front of a screen and less time spent face-to-face with patients. One estimate is that, for every hour of time spent with patients, physicians are spending another one to two hours on documentation, and the time spent documenting often bleeds into clinicians' personal time.[4] The increased "clerical burden" distracts from the real meaning of the work of medicine,[5] which is why the EMR is a likely factor in physician burnout.[6] Particularly striking is one study that found that physicians would grade current EMR systems an "F" in usability (against a standard metric for usability of technology).[7] Although the shift to keeping records electronically was theoretically intended to improve communication, patient safety, and quality, those outcomes have yet to be achieved, and discouraging errors still occur.[8] Nonetheless, the EMR has now become a necessity and requirements for documentation are likely to continue increasing.[9]

As they are juggling the administrative aspects of their job, clinicians are also acutely aware of the satisfaction surveys their patients will receive after their visits, which are often used as a measure of quality care. The HCAHPS survey includes questions on communication with clinicians, pain management, experience of the hospital environment, and satisfaction with discharge and medication information.[10] Organizationally, reduction in funding is a serious consequence of low patient satisfaction. Further, a facility's HCAHPS scores in part affect funding from Centers for Medicare and Medicaid Services (CMS), incentivizing high patient satisfaction scores. However, caregivers working in hospitals serving minority populations tend to have lower HCAHPS scores, creating a feedback loop making it more difficult for them to get funding that could improve patient satisfaction,[11] and ultimately putting more pressure on the caregivers doing this difficult work.

Clinicians have always been mindful of patient satisfaction because of the risk of litigation. Even if the prosecution is unlikely to win a case, the stress and cost of a lawsuit are themselves burdensome, given their potential impacts on reputation, financial stability, and well-being.[12] As a result, physicians have to practice defensive medicine, which is often incongruent with what they

believe to be optimal care.[13] Defensive medicine is also an obstacle to good communication,[14] which is ironic since communication issues are a key cause for lawsuits in the first place.[15]

All of these stressors are external to the practice of medicine, and the activities required of clinicians in response to these realities fall outside the scope of the practice of medicine itself. MacIntyre identifies the problems that go along with working in this kind of climate. He notes two types of activity in work, "one a mode of practice in which workers are able to pursue ends that they themselves have identified as worthwhile, in the pursuit of which they hold themselves to standards of excellence that they have made their own, the other an organization of activity such that their work is directed toward ends that are the ends of administrators and managers imposed upon their activities."[16] Later, he notes that "it matters that [workers] understand what they are doing and that their standards are ones that they have made their own, not standards imposed by external managerial control."[17] Physicians enter the practice of medicine for the healing activity of the work, but find themselves accountable to the demands that the healthcare system puts on them, which were not the same as the standards they imposed on themselves. At its worst, MacIntyre warns that individuals could be used as "cost-effective means to ends imposed by others for the sake of high productivity and profitability."[18] Yet, according to MacIntyre, growth as a moral agent is contingent upon participation in activities that an individual herself values.[19] She cannot exercise her moral agency if she feels like a cog in a machine rather than, in this case, a healer. This tension can affect practice to the point where the pursuit of the original ends of medicine is compromised. This sort of bureaucracy in medicine is nothing new. Even in the 1970s, MacIntyre lamented the ways in which the doctor-patient relationship had suffered because of it.[20]

Externally-imposed expectations for high productivity and efficiency lead to changing practice in a way that physicians know does not comport with their ideal practice of medicine. The more "efficient" the care, the less actual care can be provided.[21] Patients and families want real care, and clinicians want to give real care, but the structure makes it difficult to do so. Unsurprisingly, the results are moral distress and burnout.

Moral distress is unlike other forms of ethical dilemmas because it happens when an agent knows the morally correct thing to do, but a constraint prevents him from carrying out the action. In the case at hand, a physician knows what the goods of his practice of medicine are, and the time that needs to be spent to provide compassionate care, but the system prevents him from being able to practice in that way. Without using the term, MacIntyre describes moral distress: "exploitative

structures […] make it often difficult and sometimes impossible to achieve the goods of the workplace through excellent work."[22] It is at this point when clinicians start to burn out. Burnout is a current crisis in medicine, with about half of physicians reporting it.[23] Aside from the toll burnout takes on the individual experiencing it, in clinical settings it is linked to reduced quality of patient care.[24] It places the vocation of a physician at risk and is dangerous for patients. The prevalence of moral distress and burnout is a large-scale ethical crisis to which ethics education must attend.

It is tempting to scapegoat healthcare leaders and institutions for creating the conditions under which clinicians suffer moral distress and burnout. However, it is important to note that healthcare organizations themselves have their hands tied. Healthcare leaders are under their own kind of external constraints, as the institutions are under financial pressures to ensure their ability to provide care into the future. This reality is unlikely to change, and MacIntyre, once again, gives us a reason why. He notes that cooperative institutions that are focused on the common good, as health care institutions are, will inevitably encounter conflicts with the dominant culture, because they are calling into question that culture's values.[25] This happens frequently in nonprofit health systems, wherein a mission to care for the poor and promote healthy communities is prioritized above maximization of profits. So long as the general culture values financial success above all other goods, countercultural institutions will need to compete to continue living their missions while exercising good stewardship of resources. For health systems, that necessarily involves introducing the external pressures described above.

2. The Current State of Ethics Education in Medical Schools and Residency Programs

The threats to moral agency I have detailed make it more difficult for clinicians to offer optimal care from both a medical and an ethical perspective. Ethics education in medical schools and residency programs, however, has not been adequate in preparing students for the threats to their moral agency that they will face. First, not enough time is dedicated to ethics education. Second, the kind of bioethics that is taught when such training occurs focuses too much on principles and quandary ethics and lacks necessary resources to help morally form a person.

Not enough time is dedicated to ethics education, but that is not because students lack interest. Studies have shown that residents are not satisfied with the amount of time given for learning ethics, and they know they need more.[26] One needs assessment showed that the education being

provided is not succeeding at helping clinicians become more comfortable managing ethical dilemmas.[27] The authors developing these studies are doing good and important work, but the type of ethics education they propose in response is not the kind that will help clinicians become better moral agents. Unsurprisingly, a survey by Edmund Pellegrino, whose work on the virtues of medical practice has been foundational, found moral values "are rarely changed by courses in ethics."[28] There is an overemphasis on traditional didactic case-based education and moral analyses,[29] and a lack of content intended to help students become better moral agents under the external pressures they will face.

Often, "ethics education" for medical students and residents consists of a description of a moral quandary of some sort, an acknowledgment of the four principles of bioethics (autonomy, beneficence, nonmaleficence, and justice),[30] and then a discussion on how those principles apply to the case. These conversations can be excellent tools to help early career clinicians imagine what it would be like to encounter a particular ethical dilemma and help them understand nuanced ways to respond. Ethics education using cases and principles can push students who are comfortable learning science, where clear distinctions between right and wrong answers are more common. Through the complexities of ethics, they get exposure to grey areas. But this type of education is not sufficient. The mid-level principles of bioethics often do not give direction, as they often conflict, and there are not typically clear reasons to prioritize one principle over another.

In an essay dating from 1978, "What has Ethics to Learn from Medical Ethics?", MacIntyre writes:

> the way in which the role of the physician had been put into question by recent developments within medicine...[has] left the physician with a set of inherited rules which turned out on many types of important occasions to enjoin incompatible types of action. Hence the problems of medical ethics appear as a series of dilemmas in which moral agents look for good reasons to give weight and authority to one rule rather than another in situations of conflict.[31]

MacIntyre was reflecting on developments in medicine since the early 1900s, but the same kinds of changes can be cited in post-ACA contemporary medicine. He continues:

> what we cannot discover, however, within the stock of justifications advanced within recent moral philosophy are any grounds for giving some rules preference over others in any situation in which two or more rules provide conflicting injunctions. We therefore are left with genuine dilemmas: an agent in each type of case considers what to do on a particular occasion and has no means of deciding between rules. This is the form in which such problems are presented in most books and articles on medical ethics. Presented in this form the problems appear rationally insoluble. Presented in this form the problems *are* rationally insoluble. So the student of medical ethics turns to moral philosophy.[32]

He goes on to describe the failures of moral philosophy to respond to this kind of dilemma, and he concludes that good ethics education needs to form the moral character of the person so that she is equipped to respond to whatever comes her way.[33] Not only is every medical ethics case different depending on particularities of the situation, but the kinds of quandaries that arise are often completely unpredictable.

Consider the following common case example. Last week, when he was in and out of consciousness, a patient said he was "ready to go" and that, if his heart were to stop, he would not want any CPR. This conversation was documented, but no one was sure if he had decisional capacity and no formal advance directive exists. Today, the patient is declining, and will likely be in cardiac arrest within hours. His family is saying he did not understand what he was saying last week and is threatening to sue if the medical team does not attempt resuscitation. The team wants to continue discussing why he would have wanted "everything done," but the clock is ticking and eight other patients are waiting to be seen. Training on autonomy and nonmaleficence can help someone explain why physicians are unsure if they should perform CPR in this case, but what is really needed to provide good care in this circumstance is not knowledge of the principles of bioethics. What will actually help is being the kind of physician who is patient and a good communicator with the relational skills necessary to be attuned to the emotional needs of grieving families. The physician needs to spend the time to do good advance care planning, and to give compassionate care to patients and families—which is exactly where it has been found residents struggle, given the pressures of efficiency.[34]

As a nursing ethics professor has noted, "the realities of illness, hospital care and the effects of diminishing social health care funding are far too complex and particular to be covered by the available moral theories and abstract concepts that are still standard fare for courses in health care ethics."[35] Typical ethics education does not address a response to the underlying pressures in medicine described in the first section of this paper, which cause so much difficulty in ethical practice. Nor does it encourage a critical view on what is morally problematic with our current systems,[36] or train students to become good moral agents by forming their own concepts of the ends of their practice while resisting external systems' attempts to make their ends a physician's end.[37] In other words, ethics education needs to prepare clinicians to be moral agents in a medical system that is not set up for their flourishing.

3. What Should Healthcare Ethics Education Be Like?

What would an ideal education in ethics for medical professions be like? My first recommendation is obvious: more time needs to be dedicated to ethics in training. That is especially the case given that we need to deepen ethics education beyond principles and quandaries. Second, I propose that, in addition to a diagnosis of the problem in health care, MacIntyre also gives us the foundational content for reforming education. In what follows, I will use MacIntyre's work to suggest ways in which ethics education can change.

MacIntyre identifies "sociological self-knowledge" as a precondition for fully developing moral agency. Sociological self-knowledge is knowing "who you and those around you are in terms of your and their roles and relationships to each other, to the common goods of family, workplace, and school, and to the structures through which power and money are distributed.[38] Further, it is to "have a grasp of the nature of the roles and relationships in which one is involved, of the shared assumptions of those with whom one interacts, of what in those roles, relationships, and assumptions obstructs the exercise of rational agency, and of what the possibilities are of acting so as to transform them are."[39] More briefly, sociological self-knowledge is a kind of awareness that improves an individual's ability to navigate systems as a moral agent. By being conscious of the forces, pressures, and values of the dominant social order, a moral agent can develop the ability to rise above or at least resist that social order's expectations and make better decisions in accord with her own values.[40] For medical students and residents, developing sociological self-knowledge

must mean having a deeper understanding of the pressures they will face working in the U.S. healthcare system. Such an understanding is a precondition for resisting the system's pressures.

Another way that ethics education in health care can improve is through a commitment not only to teaching students about virtue ethics (as most textbooks in medical ethics do), but also to fostering their growth in virtue. MacIntyre proposes that virtues "are to be understood as those dispositions which will not only sustain practices and enable us to achieve the goods internal to practices, but which will also sustain us in the relevant kind of quest for the good, by enabling us to overcome the harms, dangers, temptations and distractions which we encounter […]."[41] Internal goods are those goods that can come only through the practice of an activity. External goods are likewise the results of a practice, but they are not achieved solely by practicing that particular activity. External goods often come in the form of financial compensation and prestige. They are limited resources that provoke competition, on the grounds "that the more someone has of them the less there is for other people."[42] Goods internal to the practice of medicine include promoting health and healing, developing trusted healing relationships with patients, and honoring their human dignity. External goods like financial stability and the esteem that comes from a successful, prestigious career are indeed goods, but growth in virtue leads to healthy detachment from excessive desire for them.

To be clear, the formation of virtues is unlikely to happen in a single ethics lecture, case discussion group, or ethics course. But meaningful transformation can happen through ongoing facilitated conversation, and students can learn tangible practices like asking for and receiving feedback, for "we characteristically need the judgement of perceptive and ruthlessly critical friends" to act well.[43] Even learning mindfulness techniques like noticing a behavior and assessing whether or not it is consistent with a chosen virtue can have powerful transformative effects. Literature and film can be tools for reflection on oneself and for deepening solidarity with others. Likewise, studying work from the disciplines of narrative medicine and medical humanities can aid moral formation.

Reconceptualizing ethics education as moral formation would impact both the clinician's experience of practicing medicine and patient care. Imagine a clinician who develops the humility and sociological self-knowledge it takes to recognize and reduce a bias informing the way someone cares for patients with addiction. Surely her care for patients with intravenous drug use would improve. As a further example, a hospitalist may recognize that the time needed to develop good

relationships with a family and engage in advance care planning is worth resisting the pressures of efficiency. Virtue education could also have larger-scale organizational results, empowering individuals to fight against unjust systems.[44] For example, a group of cardiologists sharing the virtue of solidarity could decide to join together and create a practice with a greater proportion of Medicaid patients, even if it means a reduction in their personal compensation. Cultivating virtues will be countercultural, as it "may and often does hinder the achievement of those external goods which are the mark of worldly success."[45]

Although they are few in number, programs doing this formative work already exist. The Physician's Formation Program through the Neiswanger Institute for Bioethics and HealthCare Leadership at Loyola University Chicago and Duke University's Theology, Medicine, and Culture Fellowship both provide in-depth formation opportunities for healthcare professionals. The program at Loyola continues through four years of medical school and helps students explore the idea of medicine as a vocation. Duke's fellowship also offers the opportunity for reflection on professional practice from a spiritual perspective. These programs are focusing on teaching goods internal to the practice of medicine, and they encourage their students to trust that a commitment to pursuit of those goods will make a difference in their institutions.[46] If MacIntyre's critique of contemporary modern moral theory is indicative of the pressures of modern day medicine in the way I argue here, the only way out of the darkness is through the creation of more programs like these.

Notes

1. My focus here will be primarily on medical students and residents, as their extensive training can provide the grounds for comprehensive ethics education, but the points I make also apply to nursing education and the training of other healthcare professionals.
2. See Bernard Prusak's introductory essay.
3. See "What are the value-based programs?" Centers for Medicaid & Medicare Services, 2020, accessed January 6, 2020, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing
4. M Tai-Seale, et al., "Electronic Health Record Logs Indicate That Physicians Split Time evenly between Seeing Patients and Desktop Medicine," *Health Aff (Millwood)* 36.4 (April

1, 2017), https://doi.org/10.1377/hlthaff.2016.0811, https://www.ncbi.nlm.nih.gov/pubmed/28373331; C. Sinsky, et al., "Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties," *Ann Intern Med* 165/11 (December 6, 2016), https://doi.org/10.7326/M16-0961, https://www.ncbi.nlm.nih.gov/pubmed/27595430

5. T. D. Shanafelt, et al., "Relationship between Clerical Burden and Characteristics of the Electronic Environment with Physician Burnout and Professional Satisfaction," *Mayo Clin Proc* 91.7 (July 2016), https://doi.org/10.1016/j.mayocp.2016.05.007, https://www.ncbi.nlm.nih.gov/pubmed/27313121
6. E. R. Melnick, et al., "The Association between Perceived Electronic Health Record Usability and Professional Burnout among US Physicians," *Mayo Clin Proc* (November 12, 2019), https://doi.org/10.1016/j.mayocp.2019.09.024, https://www.ncbi.nlm.nih.gov/pubmed/31735343
7. Melnick, et al., "The Association between Perceived Electronic Health Record Usability and Professional Burnout Among US Physicians."
8. A. J. Holmgren, et al., "Assessing the Safety of ERlectronic Health Records: A National Longitudinal Study of Medication-related Decision Support," *BMJ Qual Saf* 29.1 (January 2020), https://doi.org/10.1136/bmjqs-2019-009609, https://www.ncbi.nlm.nih.gov/pubmed/31320497; C. S. Kruse et al., "Barriers to Electronic Health Record Adoption: A Systematic Literature Review," *J Med Syst* 40/12 (December 2016), https://doi.org/10.1007/s10916-016-0628-9, https://www.ncbi.nlm.nih.gov/pubmed/27714560
9. N. L. Downing, D. W. Bates, and C. A. Longhurst, "Physician Burnout in the Electronic Health Record Era: Are We Ignoring the Real Cause?" *Ann Intern Med* 169.1 (July 3, 2018), https://doi.org/10.7326/M18-0139, https://www.ncbi.nlm.nih.gov/pubmed/29801050
10. "HCAHPS: Patients' Perspectives of Care Survey," Centers for Medicaid & Medicare Services, 2019, accessed October 19, 2019, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS
11. M. N. Elliott, et al., "Understanding the Role Played by Medicare's Patient Experience Points System in Hospital Reimbursement," *Health Aff (Millwood)* 35.9 (September 1,

2016), https://doi.org/10.1377/hlthaff.2015.0691, https://www.ncbi.nlm.nih.gov/pubmed/27605650

12. E. R. Carrier, et al., "Physicians' Fears of Malpractice Lawsuits Are not Assuaged by Tort Reforms," *Health Aff (Millwood)* 29.9 (September 2010), https://doi.org/10.1377/hlthaff.2010.0135, https://www.ncbi.nlm.nih.gov/pubmed/20820012
13. D. M. Studdert, et al., "Defensive Medicine among High-risk Specialist Physicians in a Volatile Malpractice Environment," *JAMA* 293.21 (June 1, 2005), https://doi.org/10.1001/jama.293.21.2609, https://www.ncbi.nlm.nih.gov/pubmed/15928282
14. E. Ferrand, et al., "Discrepancies between Perceptions by Physicians and Nursing Staff of Intensive Care Unit End-of-life Decisions," *Am J Respir Crit Care Med* 167.10 (May 15, 2003), https://doi.org/10.1164/rccm.200207-752OC, https://www.ncbi.nlm.nih.gov/pubmed/12738597
15. G. B. Hickson, et al., "Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries," *JAMA* 267/10 (March 11, 1992), https://www.ncbi.nlm.nih.gov/pubmed/1740858
16. Alasdair C. MacIntyre, *Ethics in the Conflicts of Modernity: An Essay on Desire, Practical Reasoning, and Narrative* (Cambridge: Cambridge University Press, 2016), 131.
17. Ibid., 170–171.
18. Ibid., 172.
19. Ibid., 131.
20. Alasdair MacIntyre, "Medicine Aimed at the Care of Persons Rather Than What …?" in *Changing Values in Medicine*, eds. Eric J. Cassell and Mark Seigler (Washington, DC: University Publications of America, 1979), 83–96.
21. See J.P. Bishop, J.E. Perry, and A. Hine, "Efficient, Compassionate, and Fractured: Contemporary Care in the ICU," *Hastings Cent Rep* 44.4 (Jul-Aug 2014): 36, https://doi.org/10.1002/hast.330, https://www.ncbi.nlm.nih.gov/pubmed/24920076
22. MacIntyre, *Ethics in the Conflicts of Modernity*, 237.
23. C. P. West, L. N. Dyrbye, and T. D. Shanafelt, "Physician Burnout: Contributors, Consequences and Solutions," *J Intern Med* 283/6 (June 2018), https://doi.org/10.1111/joim.12752, https://www.ncbi.nlm.nih.gov/pubmed/29505159

24. West, Dyrbye, and Shanafelt, "Physician burnout: contributors, consequences and solutions"; E. S. Williams, et al., "The Relationship of Organizational Culture, Stress, Satisfaction, and Burnout with Physician-reported Error and Suboptimal Patient Care: Results from the MEMO Study," *Health Care Manage Rev* 32.3 (July-September 2007), https://doi.org/10.1097/01HMR.0000281626.28363.59, https://www.ncbi.nlm.nih.gov/pubmed/17666991
25. MacIntyre, *Ethics in the Conflicts of Modernity,* 110.
26. J. Byrne, et al., "Evaluation of Ethics Education in Obstetrics and Gynecology Residency Programs," *Am J Obstet Gynecol* 212/3 (March 2015), https://doi.org/10.1016/j.ajog.2014.12.027, https://www.ncbi.nlm.nih.gov/pubmed/25530598; J. E. Chamberlain and J. A. Nisker, "Residents' Attitudes to Training in Ethics in Canadian Obstetrics and Gynecology Programs," *Obstet Gynecol* 85/5 part 1 (May 1995), https://www.ncbi.nlm.nih.gov/pubmed/11660144
27. D. B. Wayne, J. C. Muir, and D. A. DaRosa, "Developing an Ethics Curriculum for an Internal Medicine Residency Program: Use of a Needs Assessment," *Teach Learn Med* 16.2 (Spring 2004), https://doi.org/10.1207/s15328015tlm1602_13, https://www.ncbi.nlm.nih.gov/pubmed/15276898
28. Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), 176.
29. L. A. Schuh and D. E. Burdette, "Initiation of an Effective Neurology Resident Ethics Curriculum," *Neurology* 62/10 (May 25 2004), https://doi.org/10.1212/01.wnl.0000125252.41096.59, https://www.ncbi.nlm.nih.gov/pubmed/15159507; S. M. Vertrees, A. G. Shuman, and J. J. Fins, "Learning by Doing: Effectively Incorporating Ethics Education into Residency Training," *J Gen Intern Med* 28/4 (April 2013), https://doi.org/10.1007/s11606-012-2277-0, https://www.ncbi.nlm.nih.gov/pubmed/23179971
30. See Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 8th ed. (New York: Oxford University Press, 2019).
31. MacIntyre, "What Has Ethics to Learn from Medical Ethics?" *Philosophic Exchange* 2.4 (1978): 42.
32. Ibid., 43.
33. Ibid., 46.

34. See Bishop, Perry, and Hine, "Efficient, Compassionate, and Fractured: Contemporary Care in the ICU."
35. Suzanne M. Jaeger, "Teaching Health Care Ethics: The Importance of Moral Sensitivity for Moral Reasoning," *Nursing Philosophy* 2 (2001): 131.
36. See MacIntyre's commentary on business ethics in his "The Irrelevance of Ethics," in *Virtue and the Economy: Essays on Morality and Markets*, eds. Andrius Bielskis and Kelvin Knight (New York: Routledge, 2015).
37. MacIntyre, *Ethics in the Conflicts of Modernity*, 173–174.
38. Ibid., 211.
39. Ibid., 213.
40. Ibid., 211–212.
41. MacIntyre, *After Virtue: A Study in Moral Theory*, 3rd ed. (Notre Dame, IN.: University of Notre Dame Press, 2007), 219.
42. Ibid., 190.
43. Ibid., 113.
44. T. P. Daaleman, "The Medical Home: Locus of Physician Formation," *J Am Board Fam Med* 21.5 (September-October 2008): 4, https://doi.org/10.3122/jabfm.2008.05.080083, https://www.ncbi.nlm.nih.gov/pubmed/18772299.
45. MacIntyre, *After Virtue*, 198. For a more comprehensive assessment of the value of virtue ethics education in medicine, see Pellegrino and Thomasma, *The Virtues in Medical Practice.*
46. Farr Curlin and Michael McCarthy, paper presented at the American Society for Bioethics and Humanities, Pittsburgh, PA, October 27 2019.