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Virtuous Doctors and Patients: Public Healthcare as a MacIntyrean Practice

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Virtuous Doctors and Patients: Public Healthcare as a MacIntyrean Practice

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Abstract. Modern medicine has been accused of an overly-mechanistic view of the human body, and also of having lost sight of its original therapeutic goals in its service of patients' subjective desires. In this paper I want to make the case for conceiving of public healthcare using MacIntyrean virtue ethics, which can help us find the middle ground between those two extremes. As many aspects of healthcare today are driven not just by doctors' diagnoses but patient requests, e.g. assisted suicide or a disease-free child, this paper will examine in particular what makes virtuous doctors and patients, especially in public healthcare.

I. Is Healthcare a MacIntyrean Practice?

Introduction

Can medicine, or more broadly-speaking healthcare, be considered a coherent 'practice', such that those engaged in it can develop the virtues and flourish as persons? What kind of practice would it be and why does it matter? These are some of the important questions raised by Alasdair MacIntyre's account of the role of practices in virtue ethics, when he writes,

> It is not only of course with sets of technical skills that practices ought to be contrasted. Practices must not be confused with institutions. Chess, physics and medicine are practices; chess clubs, laboratories, universities and hospitals are institutions. Institutions are characteristically and necessarily concerned with what I have called external goods.[1]

Here we are told what practices–in the special MacIntyrean sense–are not: sets of technical skills or institutions, even though practices quite often involve both. But it is not immediately clear, even with MacIntyre's explanation of the internal goods which are constitutive of practices, whether chess, physics, and medicine are really the same kind of thing:

> By a 'practice' I am going to mean any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended.[2]

[1] Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, 3rd edn (London: Bloomsbury, 2007), p. 194.
[2] *Ibid.*, p. 187.

It seems, then, that some distinction is needed in order to better understand how healthcare can be conceived of as a MacIntyrean practice. This will be the first task of my paper, after which I will turn to the question of why such an approach matters, particularly in the contemporary context of public healthcare. The underlying question of this whole inquiry can be said to be this: What virtues do doctors and patients need for public healthcare to contribute to their flourishing as persons, each with their own life narrative?

Locating the Internal Good of Healthcare

As a starting point, it is useful to contrast healthcare with chess, a favourite example of MacIntyre's in elaborating the concept of a practice. Chess has clearly identifiable internal goods–that is, goods that can only be appreciated from within the practice, and achieved by practising the standards of excellence internal to that practice. Its internal goods, namely its 'highly particular kind of analytic skill, strategic imagination and competitive intensity', can be contrasted with the external goods of the practice like prestige and money, which are only 'contingently attached' to the practice 'by the accidents of social circumstance'.[3] For MacIntyre, the virtues, then, are those qualities that help us achieve the internal goods of a practice.

Note, of course, that such a use of the word 'virtue' is not restricted to its peculiarly moral sense as is more common today. Rather, it is part of MacIntyre's historically-minded project in *After Virtue* to show that the concept of virtue is rooted in the ancient Greek word *aretê*, which in Homer's use refers to excellences of various kinds, such as in athletics or warfare, each with their own conception of excellence.[4] It is through the same teleological frame of thinking–as embodied by our aiming at the internal goods of practices–that we arrive at the more specifically moral sense of the word 'virtue', used not in connection with any specific social structure or activity but in connection with the excellences of human life *qua* human life. Hence, MacIntyre ultimately seeks to link the concept of a practice, with which he offers an admittedly tentative definition of virtue that nonetheless recovers something of the old Homeric sense, to the notion of the unity of life and a moral tradition so as to provide a richer conception of virtue, whose moral and non-moral uses ought not to be fragmented.

All this is, in fact, crucial to delineating the differences between practices like chess on the one hand and healthcare on the other. What immediately becomes evident is how radically contingent the very existence of a practice like chess is on human inventiveness, compared with the way healthcare seems more basically necessary to and even constitutive of any conception of human well-being, even if its developmental history as a practice has doubtless required much human inventiveness as well. Even though both are open to an internal goods analysis, there seems to be a clear difference in the kind of practice they are, and it is this difference that may go some way in explaining the moral disagreements and conflicts peculiar to healthcare.

This difference can be conceptualised in the following way. Think, for instance, of the variety of games–each with their own rules, traditions, and standards of excellence–which go by the name

[3] *Ibid.*, p. 188.
[4] *Ibid.*, p. 122.

'football': association football, American football, Australian football. No appeal, either to the internal standards of each, or to the overall concept of 'football', can answer the question of which is the 'truest' or 'best' form of 'football'; in this respect they might be said to be incommensurable. Indeed, the question of which form of the game is most 'correct' seems unintelligible, even though all are bound by some conceptual similarities to do with the general practice of sport, perhaps the most basic of all being that they are ballgames which involve the use of the foot, which allow practitioners of each form to refer to others as 'football' with some degree of mutual intelligibility. But each form of the game can be considered its own practice, for they do not have exactly the same internal goods.

Conversely, different approaches to healthcare–for example, evidence-based medicine versus more traditional decision-making approaches–do not share the same kind of relationship with each other as do different forms of football. They are not variations on the same theme, but different approaches to achieving the same principal internal good, which is health. What is at variance is the method preferred for the achievement of that internal good, and different methods or approaches can, in principle, be evaluated and judged by the standards internal to healthcare as a whole. Whereas a group of football players could, without much difficulty, decide to vary the rules of the game in a way that leads to a distinguishably new form of football that is no less 'correct' or 'wrong' compared with its predecessor practice, in healthcare there is a point beyond which if rules and standards are varied the resultant practice can no longer be considered 'healthcare'.

This kind of difference between chess or football and healthcare is not quantitative, as if healthcare simply has a lower threshold for difference before its unifying concept falls apart, but is qualitative. Healthcare, on this analysis, only makes sense as a practice in relation to an internal good it discovers, rather than invents, whereas the internal goods of practices like chess or football are *per se* invented, even if they are invented in response to a deeper, non-invented human need for analytical challenge or competitiveness in physical prowess. Healthcare, then, is more like the practice of physics or other natural sciences, for example.

In this respect, separate attempts by David Miller and Derek Sellman to make distinctions between different types of practices do not adequately capture this particular difference that I have identified. In his paper 'Virtues, practices and justice', Miller introduces the distinction between 'self-contained' practices like chess, whose '*raison d'être* consists entirely in the internal goods achieved by the participants' and 'purposive' practices which serve social ends that go beyond these internal goods.[5] Yet can chess not be said to serve the further social end of providing an intellectually stimulating leisure activity? Pursuing a different line of argument, Sellman uses his discussion of nursing as a MacIntyrean practice to introduce the term 'professional practice', by which he means not a professional occupation but a practice that involves 'a degree of commitment not necessary for the game of chess'; notwithstanding those who become professional chess players, chess is generally played out of 'inclination rather than necessity', whereas nursing requires a particular particularly continuous engagement that to the care of human lives that it can be said, on Sellman's view, to

[5] David Miller, 'Virtues, practices and justice' in John Horton and Susan Mendus (eds), *After MacIntyre: Critical Perspectives on the Work of Alasdair MacIntyre* (Cambridge: Polity Press, 1994), p. 250.

require 'a commitment that transcends the commitment to a practice as such'.[6] Sellman's distinction comes closer to what I have been trying to articulate, but it is not clear why the kind of commitment he describes to the patients one cares for cannot be seen as internal to the very logic of the practice itself.

What both distinctions, when applied to healthcare or medicine, miss is how the good of health ought really to be seen as something so internal to healthcare, such that 'normative concepts in medicine like health and disease, as well as in the doctor-patient relationship, arise from within medicine'.[7] Whereas many other practices deal with realities that can in principle be changed without harm to the conceptual coherence of the practice, such as the different pieces on a chess board or the shape of a football, the principal internal good of healthcare–namely, human health and well-being–has to do with the human body, which has standards of operational excellence that exist prior to healthcare, but come to set both the limits and possibilities of the practice of healthcare from within. By contrast, it would make no sense to ask what shape a football ought to be without reference to the particular game being played. So the internal good of healthcare as a practice, I contend, is something discovered by practitioners rather than invented by the tradition of the practice, and it is truly internal in that it is neither a further social aim (as per Miller's distinction) nor a transcendent object of commitment (as per Sellman's distinction).

Looking back, it seems clear, then, that healthcare can be thought of as a MacIntyrean practice, in that it is a complex human activity requiring a huge degree of social cooperation, with goods internal to it achieved by practising the standards of excellence that have been developed and perfected through a long, continuously evolving tradition. But it is also distinct from many other invented practices like chess, in how very closely bound it is to the excellences of human life *qua* human life. Of course, all human practices will likely require specifically moral virtues like honesty and justice to properly function, but the internal goods of healthcare are so directly related to the goods of human life that it might be called an 'intrinsically… moral enterprise'.[8] This is what distinguishes healthcare from practices like biology or physiology, whose principal internal goods are also discovered and not invented, but unlike healthcare are not *per se* oriented in a practical way towards the goods of human life.[9]

One final point to be made here concerns whether we should speak of medicine or healthcare as a practice. While it seems to me that the clinical encounter between the doctor and the patient is at the heart of this practice, to limit its scope too narrowly to 'medicine', as in that which the doctor practises, is to ignore the vital contributions of other participants in the whole system that enables the doctor-patient relationship to flourish. Peter Toon's suggestion that 'what goes on in the

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[6] Derek Sellman, 'Alasdair MacIntyre and the professional practice of nursing', *Nursing Philosophy* 1 (2000), pp. 29–30.

[7] David C. Thomasma, 'Establishing the Moral Basis of Medicine: Edmund D. Pellegrino's Philosophy of Medicine', *Journal of Philosophy and Medicine* 15 (1990), p. 249.

[8] *Ibid.*

[9] Thomasma insightfully writes, 'Medicine is neither science nor art, but a *technê iatrikê,* a practical discipline of healing. Thus, medicine is not theory about the body or how the body works, so much as theory about practice, about the ways in which doctors and patients, other health professionals, and institutions interact to bring about healing. Within this context anatomy, physiology, and the other sciences assist both understanding and practice.' (p. 248)

institutions we call hospitals and health centres are not separate practices of medicine, nursing, health service management, etc. but one common practice of health care' seems right, and the internal goods can range from 'carrying out an operation' to 'administering an appointment system efficiently'.[10] Yet Toon, who writes with personal experience as GP, is all too aware of what MacIntyre calls 'the corrupting power of institutions'–for institutions, as conceptually distinct from practices, are more primarily concerned with the external goods.[11] In healthcare this might be the managers who look into the cost effectiveness of a hospital or who handle the salary schemes of employees, and Toon cautions against the effects of 'managerialism' on the practice of healthcare.[12] Nonetheless I do not think this necessarily precludes the more institutional aspects of healthcare from being a genuine part of the MacIntyrean practice, so long as they are still in some way subordinated to the fundamental internal goods of healthcare, and not aimed at serving social ends that may be contrary to the internal goods of health and well-being.

With all this in mind, we can now turn to the question of why conceiving of healthcare as a practice for the virtues matters in the contemporary landscape of healthcare and its particular debates.

II. Practising the Virtues: Between Mechanism and Subjectivism

Virtues, Practices, and Life Narratives

Having established what, in my view, is distinct about healthcare as a practice compared with, say, chess or football, it is apt to consider why this distinction–and all this talk of practices and virtues–might be relevant. I will first lay the groundwork regarding the basic features of healthcare as a practice for the virtues, before turning to consider how this can help us overcome a distinctive challenge of contemporary healthcare: the opposing yet complementary forces of mechanism and subjectivism.

The idea of healthcare as a practice, with human health and well-being as its principal internal good, brings back into focus a teleological form of thinking easily overlooked with other medical ethical approaches like Beauchamp and Childress's four principles, or deontological theories that strongly emphasise rights and duties. The value of this way of thinking also lies in its taking into account of the motivations and emotions of each individual moral agent involved in the enterprise of healthcare.[13] Returning to the opening insight of Aristotle's *Nicomachean Ethics*, which is that '[e]very art and every science… and in like manner every action and moral choice, aims, it is thought, at some good',[14] we can think of the virtues–broadly conceived–of the healthcare professional as including technical skill, intellectual acumen, and of course the stable dispositions of character that

[10] Peter Toon, *A Flourishing Practice?* (London: Royal College of General Practitioners, 2014), pp. 32–3.

[11] MacIntyre, p. 194.

[12] Toon, pp. 13–5.

[13] See, for instance, P. Gardiner's discussion of the virtues in healthcare in 'A virtue ethics approach to moral dilemmas in medicine', *Journal of Medical Ethics* 29 (2003), 297–302.

[14] Aristotle, *The Nicomachean Ethics of Aristotle*, trans. D. P. Chase (London: J. M. Dent & Sons, 1911), 1094a. Aristotle also states here that ends 'likewise come to be many: of the healing art, for instance, health'.

facilitate the achievement of good health and therefore human flourishing for patients. Here it should not be forgotten that patients, too, have their own relevant virtues to cultivate as they too are active players in the pursuit of their own health. This is particularly so in the modern healthcare context that eschews medical paternalism and elevates patient autonomy. It might be said that the teleological character of the practice of healthcare gives content and meaning to the autonomy of doctors and patients alike; autonomy is not simply free choice in a value-free or neutral world, but is both the means by which good is chosen as well as a constitutive part of that very good, since autonomy is characteristic of a human life in good health.[15]

That virtue ethics seems to offer an attractive 'middle way' to consequentialist and deontological approaches to ethics is a familiar theme, and one which I shall not rehearse here. But of particular note in this paper is that virtue ethics, when considered in a communitarian or collaborative context like the practice of healthcare, has the advantage of presenting 'professionals and patients as collaborators in a struggle against suffering and incapacity: as "co-producers of health" rather than opponents'. Toon contrasts this model with 'an adversarial right or legalistic concept of patient autonomy or a consumerist view of patient satisfaction'.[16] This is especially significant when considered alongside one of MacIntyre's major themes in *After Virtue*, which is the concept of unity of a life narrative. For MacIntyre, it is important that practices not remain fragmented from one another in life but contribute to an overall narrative unity of life,[17] which gives intelligibility to our actions and orders the different goods we seek. In this narrative unity, then, the virtues are '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 [overall] good'.[18]

With this in mind, the doctor-patient relationship can be seen as one of interlocking life narratives moving towards shared goals, and of course ultimately towards human flourishing. The patient's medical history comes 'alive', as it were, not as a series of brute facts but as a narrative being lived out, whose story has now been brought into an encounter with the narrative of the professional. Here the patient's autonomy finds its place because it is the patient who is, ultimately, the best judge of his own unfolding narrative and so his point-of-view is, one might say, epistemically privileged. The doctor's duty of beneficence also finds its place because, quite obviously, that is the very reason why he has been consulted–yet were he to act out of that duty in a way that compromises the patient's autonomy, that would, at least in general, also compromise the very narrative unity of the patient. Rather than seeing beneficence and respecting patient autonomy as 'potentially conflicting duties'[19] of the doctor, autonomy should instead be seen as constitutive of

[15] Toon insightfully writes, 'If however autonomy is seen not as a static concept, a moral or legal "right", a possession to be treasured and protected from others, but instead is seen as an internal good, a capacity to be developed as we face the challenges of life, part of the human power to achieve excellence, an aspect of the virtues and *eudaemonia*, then the practice of health care becomes one way in which autonomy can be enhanced for those who participate as patients.' (p. 34)

[16] *Ibid.*, p. 34.

[17] *Ibid.*, pp. 34–5.

[18] MacIntyre, pp. 204–25.

[19] Toon, p. 34.

the patient's good. Both, nonetheless, must strive to orientate themselves towards the authentic internal goods of healthcare, and not be distracted by the external goods.

All that is not to say that conflict will simply disappear with this new frame of thinking; but when there is conflict, the virtuous doctor who has life narratives in mind will not strive to resolve the situation by, say, simply informing the patient of their professional opinion about the treatment at the heart of the dispute. In this respect P. Gardiner presents a useful analysis of the 'standard' case of an adult (and therefore competent) Jehovah's Witness patient who refuses a blood transfusion for religious grounds. Gardiner suggests some points for consideration in this clinical encounter:

> Is [the doctor] motivated to transfuse him to improve her productivity figures or does she genuinely want to help this individual find a solution to this particular predicament? Is the patient motivated freely and sincerely by faith or is there an element of coercion from his religious community or indeed his family?[20]

Although Gardiner does not use MacIntyre's language, the allusion to 'productivity figures' is a clear recognition of the way external goods can be a distraction to the pursuit of the internal goods. More interestingly is the attention drawn to the life narrative of the patient. If the patient is firm in his religious conviction then the doctor's ability to act out of his duty to beneficence would be limited, for the doctor must respect the form of narrative unity chosen by the patient that at this point is incommensurable with the doctor's position, thus limiting the extent to which their narratives can interlock at all. But if, for example, it turns out that patient admits he is the subject of coercion when he truly cannot find a reason in conscience to refuse the transfusion (perhaps he has stopped practising the faith but has not told his family),[21] then this recovery of a sense of autonomy not only opens the path to treatment but also leads to the disentangling of an element in his life narrative that has been hitherto compromised. In this way, the patient's autonomy comes to form a crucial part of the internal good aimed at by both him and the doctor, and the virtues of honesty (about one's faith), courage (to stand by one's decision), compassion (for the patient's predicament), justice (regarding what is owed the patient), and prudence (in how to discuss personal histories) take centre-stage in this difficult decision-making process.

Mechanistic and Subjectivist Trends in Medicine

So far we have been developing two strands of thought: firstly, that the internal good of health is discovered, not invented, and secondly, that healthcare as a collaborative practice for the virtues can also be seen in the wider context of flourishing life narratives. Working on the assumption that human life as a whole can indeed be evaluated teleologically, it becomes even clearer why healthcare is, as mentioned earlier, an 'intrinsically moral enterprise'. While human flourishing–indeed the very notion of there being a 'narrative' we can live and seek unity through–must ultimately be evaluated in the context of humans as rational and social animals, it seems that this flourishing must also

[20] Gardiner, p. 299.

[21] This would of course be different from if the doctor decided to take it upon himself to dissuade the patient of his religious views, which would be an abuse of the doctor's professional role.

include the normal, healthy functioning of the human body in accord with what Philippa Foot has termed the 'patterns of natural normativity'.[22] As Foot puts it in her exploration of the natural teleology of the body:

> We start from the fact that it is the particular life form of a species of plant or animal that determines how an individual plant or animal should be… all the truths about what this or that characteristic does, what its purpose or point is, and in suitable cases its function, must be related to [that species'] life cycle. The way an individual *should be* is determined by what is needed for development, self-maintenance, and reproduction: in most species involving defence, and in some the rearing of the young.[23]

In light of this we can then speak of the natural defects of a particular individual member of a species.

This does not mean, of course, that the human individual who suffers from a particular defect is therefore guilty of some *moral* defect–not necessarily, anyway, until one brings in personal choice. For if human flourishing gives us a certain standard of normativity, and human health is a constitutive part of that flourishing, then healthcare would not be an optional practice like chess or even physics would be, but something that ordinary human responsibility must be engaged in. I mean 'healthcare' here in the broadest possible way, that is, not necessarily going to see a doctor regularly but at the very least the personal maintenance of one's health and well-being.

Seen in this way, the concept of patient autonomy comes to signify something far richer than the mere legal right to autonomy. Yet, in the contemporary landscape of healthcare, just as one starts to look to the body for a source of normativity, one immediately notices two forces coming from opposite directions but conspiring to recast the meaning of patient autonomy: on the one hand, medicine becoming conceived of as the vehicle for the fulfilment of subjective patient desires,[24] and on the other, medicine as a mechanistic approach towards the staying of bodily death.[25] How does healthcare conceived of as a MacIntyrean practice for the virtues matter in relation to–perhaps in resistance to–these forces?

We might start by diagnosing the problem. Willem Jacobus Eijk points to the Cartesian separation of mind and body as the root of the body being instrumentalised by the mind: if the body is 'conceived as something extrinsic to the human person, reduced to the human mind' then the

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[22] Philippa Foot, *Natural Goodness* (New York: Oxford University Press, 2001), p. 38.

[23] *Ibid.*, pp. 32–3. Elizabeth Anscombe makes a similar point about normativity in 'Modern Moral Philosophy' when discussing Hume's is-ought distinction, arguing that at least for the word 'needs' rather than 'ought', one can in the case of a plant speak of what environment it 'needs' in order for it to flourish, and this transition from 'is' to 'needs' indicates a certain kind of truth or fact. See 'Modern Moral Philosophy', *Philosophy* 33/124 (1958), pp. 6–8. Anscombe, like Foot, was of course deeply sceptical of the peculiarly moral force that the word 'ought' was supposed to possess; *c.f.* Foot, 'Morality as a System of Hypothetical Imperatives', *The Philosophical Review* 81/3 (1972), 305–16. Nonetheless it seems that on the basis of natural teleology one can recover a different sense of the word 'ought', in the light of what a particular species needs or ought to have for its flourishing.

[24] See, for instance, Willem Jacobus Cardinal Eijk, 'Is medicine losing its way? A firm foundation for medicine as a real *therapeia*', *The Linacre Quarterly* 84/3 (2017), 208–19.

[25] See, for instance, David Arriola, 'Medicine, Machines, and Mourning: The Formation of Physicians and Praying the Psalms', *Christian Bioethics* 23/1 (2017), 7–21.

body is disposable or amenable to being used as a 'means to realize self-chosen ends'.[26] This might give context to some of the disputes that occur between beneficence and autonomy, such as when a patient requests for physician-assisted suicide on a ground not permitted by the law (which is not to imply that I think such a procedure would otherwise be in accord with beneficence were it within the law) and is as such refused. It is not simply that the patient's autonomous choice has been judged incommensurable with the doctor's desire to act for the patient's beneficence, as perhaps in the case of the Jehovah's Witness patient who remains resolute in faith, but that in an extreme case autonomy has been elevated to being an unquestionable, infallible source of judgement–not just a good in itself but *the* arbiter of good.

Yet the flipside of this Cartesian separation must not be ignored, for the advance of medical technology has also facilitated the rise of a more mechanistic conception of the body. David Arriola, drawing on Jeffrey Bishop's book *The Anticipatory Corpse*, describes this vision of medicine as privileging a 'mechanical metaphysics that focuses solely on material and efficient cause', to the extent that the corpse becomes the 'epistemological norm' of medicine.[27] If all is mechanical and material, then the non-moving body becomes the norm, although medicine has the apparent 'power of efficient causation to keep matter moving'.[28] Of particular significance for our discussion is what this means for patient choice and the medical profession. This vision of medicine, it is contended, turns doctors into mere 'cog[s] in the machine, a dispenser of adequate medical technology', while choice lies with the patient whose body is the subject of medicine's efficient power.[29] Exerting a pressure from the opposite direction, then, this mechanistic view of the body serves to complement the subjectivist perspective on patient autonomy discussed above. While it might seem that this conception of medicine would turn the role of the doctor and his professional judgement into something more 'objective', the upshot of this would be the diminishment of the importance of conscientious objection, for example, which would have no obvious place in such a mechanistic schema. But even apart from that, the doctor's role in this view would simply be the provision of technical expertise onto a value-less body, thus opening the path to a consumerist model of healthcare–since, in the absence of 'natural normativity', patient choice remains as the only indisputable source of value creation, at least for one's own body.

In response, we must return to the living body as a source of normativity–not just the body as mere sub-rational matter, but rather the body as informed by and united to its life principle, which some call the soul. The view of 'natural normativity' and teleology mentioned earlier will help overcome an overly mechanistic metaphysics, but to counter the subjectivist viewpoint what is needed is a conception of a more intimate union between body and rationality than the rather incidental unity of mind and body envisaged by Cartesian thinking. This, it seems to me, finds articulation in the Aristotelian-Thomist tradition of the 'substantial unity of soul and body'–the soul being the 'form' of the 'matter' of the body.[30] In less Scholastic terms, this can be understood as the

[26] Eijk, p. 213.
[27] Arriola, p. 9.
[28] *Ibid.*, pp. 10–1.
[29] *Ibid.*, p. 11.
[30] Eijk, p. 214.

sub-rational matter of the body fully participating in the rational life of the human organism, whose rationality does not override biology but takes biology to be a reference point for the human organism's obviously indisputable freedom to pursue flourishing. Biology is not limiting freedom so much as giving the foundation and content of autonomy, rather than being treated as the 'raw materials' of autonomy. It is with such a vision of human body in healthcare, supported by the MacIntyrean model already outlined, that the excesses of these two tendencies can then be neutralised. It should not be surprising for us to perceive how, if healthcare is conducive to a virtue ethics framework of thinking, it can and is also the ground of some of the most fundamental disputes about virtue. After all, as argued healthcare is inseparable from the nature of the human body. The virtues we envisage for healthcare will obviously depend on our background picture of human nature, be it a body-soul union or a Cartesian philosophy of mind.

It is important thus to consider how the MacIntyrean-practice model, with the body–or rather, body-soul–as the source of its discovered internal good, is different from the mechanistic and subjectivist conceptions. The mechanistic view of the body is in fact completely antithetical to the notion of a life narrative of the organism, while the subjectivist view (in an extreme form) sees the body as pliable raw materials for the patient's narrative- and value-creation. In this schema of self-interpretation, it is impossible to construct a proper account of the virtues, since there is no true teleology to speak of, and the stability of any dispositions formed for the subjective goals chosen by the patient is threatened at its foundations by the possibility that those goals may change at will. In in the clinical encounter, it is not that beneficence and autonomy may clash, but rather that autonomy creates beneficence. The doctor's virtues would be reduced to mere know-how, to be deployed in relation to shifting internal goods of the practice. This is in sharp contrast with healthcare conceived of as a MacIntyrean practice, where properly functioning collaboration is in fact a constitutive part of the flourishing of the practice and its participants, and such collaboration is oriented towards the internal good of health and well-being in the life narrative of a patient whose story is, as it were, already partially written by the body's own nature. What one's rationality does is in part discover the nature of the body's biological life, and find a narrative unity between that biology and the more rational and social aspects of life. The virtues are those qualities that help both the patient and the doctor continually write this narrative, uncovering taking into account the 'story of the body' hitherto written, and bringing the patient's narrative closer towards its flourishing end.

III. The Virtues in Public Healthcare

Being Virtuous Patients

In what remains of this paper, I want to turn to two particular issues in healthcare where patient autonomy is of particular interest, and briefly consider them in light of the preceding discussion about the virtues and autonomy. One concerns the supposed 'right' to assisted suicide that some jurisdictions have introduced, and the other concerns new genetic techniques that allow or may allow the deliberate creation of children to be free from some inheritable condition–often seen as

the first step towards 'designer babies'.[31] What virtues might we speak of in relation to patients in these circumstances, and how does the fact that these new interventions may take place in societies where healthcare is largely publicly-funded (such as in the UK) affect our evaluation?

While both interventions appear radically different, they are both amenable to an analysis in the light of life narratives and practices for the virtues. No doubt in both cases, the context of patient autonomy is different–in one, it has to do with terminating suffering and deciding the time and manner of one's death, in the other, it is about procreative control.[32] Are these acceptable forms of writing one's life narrative, and are they in line with the internal good of human health?

The first thing that can be said is that in both instances, the biological matter of the body is being treated precisely as raw material for subjective interpretation in a way discussed in the last section. Both actions, it would appear, go against the natural instinct for survival and self-maintenance, and the normative mode of human reproduction. It seems, in the case of assisted suicide, that if we *are* our bodies, as per a Thomistic body-soul union approach, and our bodies provide the foundation for our life narratives then the act of deliberately choosing the termination of one's bodily life becomes unintelligible for it is a literally self-contradicting move in one's narrative. With regard to the issue of assisted reproduction for control of disease-inheritance, there is a question about whether this form of reproductive control is conducive to the flourishing of the social relationship between parent and child or if this form of minute control over procreative details is in fact detrimental to such a socially foundational relationship.[33] There is more that can be said about either issue, but here our concern is also that the virtue ethics framework we have been developing demands that we go beyond mere ethical evaluation of rights and wrongs, and ask how the virtuous doctor would respond, and how the virtuous patient would react.

In the context of a collaborative practice as healthcare ought to be, the doctor who receives such requests (and who is firmly opposed to these interventions) will want to find out more about the life history of the patient motivating either request. What quickly becomes apparent about the practice of healthcare is that in fact, because as I have emphasised it is so closely tied to the goods of human life *qua* human life, the proper practice of healthcare transcends the visible institutions that regulate the professional practice and administer the external goods. In both cases a vital question to be asked is: What is the social support available (or lacking) in the patient's life for disability support? It is clear the practice of healthcare leads one to consider, not simply the doctor-patient relationship, but the wide-ranging life narrative of the patient that is hopefully moving towards a greater sense of unity. On the patient's part, brought to the foreground of such scenarios are the virtues of courage to face adversity (of one's own or one's child's) and the clarity of mind to perceive the possibly less-than-conscious rejection of one's bodily narrative and nature, and the continued cultivation of the

[31] At present mitochondrial replacement techniques are always legal for clinical use in the UK but the gene-editing of embryos is still at an experimental stage and not used anywhere for pregnancy.

[32] Some would argue that this form of procreative control is also motivated by beneficence for the future generation, although this argument would have to overcome the non-identity problem to have weight.

[33] This is, of course, but the briefest of sketches of an argument against these forms of medical interventions based on a 'natural normativity' approach to healthcare ethics; naturally such an argument will need to be developed further but this is not the main focus of the present paper.

virtue of friendship in order to find in disability and possibly long-term suffering real potential for human flourishing.

A final thought is in order here about whether we can speak of the virtues involved in the doctor-patient relationship as 'public virtues', especially if the relevant healthcare institutions are publicly funded. It would seem that even though the doctor-patient relationship requires due confidentiality, because these virtues come from the teleology of the human body–and hence a shared human nature–they could not be anything but public virtues, in that they are for everyone and not simply for the participants of a restricted practice. Put in a different way, because the practice of healthcare is at heart a common duty and responsibility of everyone–regardless of how frequently or infrequently we interact with the institutional aspects of healthcare–everyone is thus called to be a virtuous keeper of one's own health. But where healthcare is concerned as a publicly-funded institution, the virtue of justice suggests some considerations not just about what the patient ought to ask of the state or not in view of limited resources, but also about what the community who collectively fund the institution ought to seek for public healthcare to provide. For the question the doctor asks a patient of what social support they require inevitably turns to the question of what the wider community then is prepared to provide through its public funding and political decisions about social support structures. These closing reflections suggest that the notion of healthcare as a MacIntyrean practice is in fact a far more complex one than the more narrowly considered moral enterprise of medicine that, nonetheless, is still the centrepiece of healthcare. But given that healthcare is so deeply intertwined with human life itself, the virtues of healthcare ultimately cannot be seen apart from the virtues the political community in which we all live requires for its collective flourishing.

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