

MEDICAL EDUCATION

Courage and Compassion: Virtues in Caring for So-Called “Difficult” Patients

Michael Hawking, MD, MSc, Farr A. Curlin, MD, and John D. Yoon, MD

Abstract

What, if anything, can medical ethics offer to assist in the care of the “difficult” patient? We begin with a discussion of virtue theory and its application to medical ethics. We conceptualize the “difficult” patient as an example of a “moral stress test” that especially challenges the physician’s character, requiring the good physician to display the virtues of courage and compassion. We then consider two clinical vignettes to flesh out how these virtues might come into play in the care of “difficult” patients, and we conclude with a brief proposal for how medical educators might cultivate these essential character traits in physicians-in-training.

Virtue is what makes its possessor good, and his work good likewise.
Aristotle [1]

Introduction

In his 1978 article, “Taking Care of the Hateful Patient” [2], James E. Groves wrote about “those [patients] whom most physicians dread” [3]—patients who, as others have noted, seem to display “behavioral or emotional aspects” such as “psychiatric disorders, personality disorders, and subclinical behavior traits” that, while not necessarily related to their primary medical condition, nonetheless complicate their care [4]. What, if anything, can medical ethics offer to assist in the care of such patients? Modern health care ethics frameworks—typically utilizing deontological or consequentialist reasoning—respectively focus on rules and principles or pursue a decision that’s likely to bring about the greatest good for the greatest number. In contrast, virtue ethics calls our attention to a physician’s character.

Virtue Ethics and Medicine

Edmund Pellegrino [5] writes that virtue ethics is “the oldest philosophical foundation for moral conduct” [6]. It traces its roots back to Plato and Aristotle, was reinvigorated and bolstered by the likes of Averroes and Thomas Aquinas in the Middle Ages, and fell out of favor around the time of the Enlightenment [5]. In the 1980s, G. E. M. Anscombe’s essay, “Modern Moral Philosophy,” and Alasdair MacIntyre’s *After Virtue* brought the tradition

back into conversation with modernity, and Pellegrino and others have brought the tradition's insights to bear on clinical practice [5, 7-11].

Rather than focusing on rights, duties, or utility maximization, virtue ethics focuses on the cultivation of certain traits—virtues—that, taken together, dispose an individual to act justly in a particular situation [10]. James Rachels, drawing on Aristotle, defines a virtue as a “trait of character, manifested in habitual action, that is good for a person to have” [12]. These traits, which are developed through practice, are necessary for an individual to flourish. “Flourishing” has come to be the preferred translation of Aristotle's concept of *eudaimonia*, which means something like “living well” or “faring well” [13]. It conveys an active state of genuine well-being and fulfillment.

To give a concrete example of a virtue that will be familiar to anyone in medicine, consider the virtue of temperance. A temperate person exhibits appropriate self-control or restraint. Aristotle describes temperance as a mean between two extremes [13]—in the case of eating, an extreme lack of temperance can lead to morbid obesity and its excess to anorexia. Intemperance is a hallmark of many of our patients, particularly among those with type 2 diabetes, alcoholism, or cigarette addiction. Clinicians know all too well the importance of temperance because they see the results for human beings who lack it—whether it be amputations and dialysis for the diabetic patient; cirrhosis, varices, and coagulopathy for the alcoholic patient; or chronic obstructive pulmonary disease and lung cancer for the lifelong smoker. In all of these cases, intemperance inhibits a person's ability to flourish. These character traits do, of course, interact with social, cultural, and genetic factors in impacting an individual's health, but a more thorough exploration of these factors is outside the scope of this paper.

How does one come to be virtuous? Consider the case of a prediabetic patient who, through conversations with his doctor and reading on his own, realizes that he is teetering on the edge of a serious medical condition and resolves to change his lifestyle. He might begin by foregoing his usual morning donut. He will probably struggle at first, but after choosing a healthier option several days in a row, choosing will become easier. Next, he may give up his afternoon soda and late-night snacks. As he chooses day-in and day-out to resist his appetites for tasty, high-carb foods, he will grow in temperance to the point that refusing unhealthy foods becomes a habit. Thus, by practicing temperance with respect to tasty but unhealthy foods, the patient will have redirected his trajectory away from diabetes and towards better long-term health.

Virtues are thus habits of character cultivated through practice that result in the actions essential for an individual to flourish. What then, does this mean for practitioners of medicine? Pellegrino wrote that the medical virtues “focus primarily on those traits necessary to do the work of medicine well. The good that medicine seeks ... is ultimately the preservation, promotion and restoration of health” [14]. Pellegrino lists what he

takes to be six essential virtues for the clinician: *fidelity, honesty, compassion, effacement of self-interest, courage, and justice* [5]. Defining, defending, or expanding this list is beyond the scope of this essay, but to illustrate the importance of medical virtues, we focus on two of these six—namely courage, or the strength of character that enables one to do what is appropriate or necessary in the face of fear or aversion [1], and compassion, or what Beauchamp and Childress describe as “an active regard for another’s welfare with an imaginative awareness and emotional response of deep sympathy, tenderness and discomfort at another’s misfortune or suffering” [15]. As we will see, courage and [compassion](#) are especially essential in the care of the “difficult” patient.

The “Difficult” Patient

As noted above, some have drawn attention to those patients who make “repeated visits without apparent medical benefit, patients who do not seem to want to get well, patients who engage in power struggles, and patients who focus on issues seemingly unrelated to medical care” [4]. Groves [2] attempts to categorize “difficult” patients into four types: *clingers* (needy patients who evoke aversion and need clear boundaries), *demanders* (entitled patients who use intimidation, devaluation, and guilt to get what they want), *help-rejecters* (pessimistic, needy, nothing-works patients who evoke self-doubt), and *self-destructive deniers* (who display self-destructive behavior, ignore recommendations, and evoke strong negative feelings). Any student or clinician who has been in practice can recognize, and likely conjure particular memories of, patients who fit these categories. Caring for “difficult” patients is an inescapable part of medicine, and thus learning to care well for these patients is an essential part of physician formation. The examples of *demanders* and *self-destructive deniers* particularly help to illustrate the importance of courage and compassion in clinical practice.

Demanders. Imagine walking into an office visit with a patient who suffers from chronic low back pain and [narcotic dependence](#). This patient is well-known to you; on your last visit you had discussed weaning the narcotics prescribed by his previous physician. “Doc, I need a refill! I ran out and the pain is unbearable!” the patient exclaims without any evidence of distress. You check the state’s database and see that he filled his month’s prescription ten days ago. You reiterate the need to transition off narcotics and the patient reacts with outrage: “Don’t you care about my pain? It’s terrible! You’re an awful doctor.”

To remain firm in one’s refusal of narcotics for this patient requires a certain degree of courage. It would certainly be *easier* to refill the prescription and send him on his way. That would avoid the discomfort the physician would likely experience after refusing the patient’s request, as patients with substance use disorders can escalate these situations through coercive language or threatening to file complaints. Nevertheless, the good physician will stay the course and refuse demands for treatments that the clinician

believes are not indicated, even when doing so means withstanding hostility from the patient. At the same time, a good clinician will resist the temptation to resent such patients and write them off as manipulative drug seekers. Here, the virtue of compassion enables a clinician to suffer with a patient, imaginatively calling to mind and lamenting that patient's experience of pain and addiction. Compassion promotes empathy rather than resentment and thus facilitates a healthier patient-clinician relationship.

Self-destructive deniers. Now imagine a patient whom you are seeing in the ICU. She is immunosuppressed and very sick with what will likely be a terminal pneumonia; furthermore, she is intermittently refusing to take the antibiotics you have prescribed for her while also refusing to consider home hospice. You discover that her pneumonia developed at least in part because she was not taking her prophylactic medications at home. Repeated goals-of-care conversations have only resulted in the patient and her family growing increasingly hostile to the care team. When a nurse pages you yet again to tell you that the patient is refusing today's dose, you might feel exasperation. You might dread another conversation with the patient, and it would be easy to simply ask the nurse to skip the dose.

The patient's health, however, hangs in the balance. Here, courage can equip a clinician to try yet again to form an alliance with a patient and persuade her to cooperate in her care—despite fearing that these efforts will fail while only consuming limited time and energy. Furthermore, compassion can enable a clinician to imagine and regret the helplessness and anxiety the patient might experience and to remain in solidarity with her simply because she is sick—notwithstanding how challenging it is to care for her. Compassion can evoke efforts to understand the roots of a patient's noncompliance and resistance, and courage can sustain a clinician in those efforts when doing so is difficult. Together, these virtues help to overcome conflict in the patient-clinician relationship that otherwise frustrates the possibility of healing.

Courage and Compassion as Virtues Necessary for Medical Practice

Martha Nussbaum and Amartya Sen discuss virtues as traits needed to overcome the challenges of life [16]. So understood, the medical virtues are traits needed to overcome challenges in clinical practice. So-called "difficult" patients test clinicians' characters, requiring and calling forth virtues such as courage and compassion. Susan D. McCammon and Howard Brody note that "the ultimate development of virtuous character" is exemplified when "such actions are habitual and are defaulted to even in times of significant stress" [17]. Without such virtues, a clinician might respond to a so-called "difficult" patient with aversion, pacification, and resentment, and could thereby fail to act in ways that facilitate that patient's healing. As Thomas Percival initially noted and Jack L. Coulehan has reiterated, physicians in their care of patients must unite "tenderness with steadiness" [18, 19].

A number of authors have argued that medical schools should make concerted efforts to instill virtues in their students [5, 7-9, 11, 17, 19, 20-21]. Such efforts will in no small part involve positive role modeling by virtuous faculty, and, as Kyle E. Karches and Daniel P. Sulmasy note, such modeling will necessarily resemble “the way in which a master musician teaches a student”—a kind of longitudinal “apprenticeship” with an exemplar “capable of recognizing and cultivating excellent performance” [22]. Educators can model what virtuous behavior looks like for their students and trainees. Virtuous exemplars can thereby help counteract the “hidden curriculum” of medical training, through which corrosive values and behaviors are so often displayed by resident and attending clinicians and thereby habituated in medical students [8, 23]. Some have argued for an educational model of formation in which lives of service are created and sustained in intentional learning communities that link the “lived experiences of mentors and learners with an interdisciplinary set of didactic materials” [20]. Schools that have adopted a similar model of moral formation tend to emphasize the use of narrative, the creation of a rich community of learners, and intentional [reflective processes](#) in a longitudinal curriculum that fosters an apprenticeship model of clinical education [20, 21, 24].

At all stages of medical education, clinicians can be trained to practice with courage and compassion. Repeated practice allows these traits to settle in more deeply as habits of character that equip clinicians to act in ways that facilitate their patients’ healing—even when patients’ behavior makes the clinicians’ task more difficult. So-called “difficult” patients can push physicians to their limits, but, as was illustrated in the cases above, deeply ingrained courage and compassion enable a clinician to push through the difficulties to pursue patients’ health even in the most challenging of circumstances.

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Michael Hawking, MD, MSc, is a first-year resident physician in internal medicine at the University of Chicago. He is also a research scholar at the Hyde Park Institute and coordinates its medical ethics programming. He received an MD from the University of Michigan, an MSc in comparative social policy from the University of Oxford, and a BA in philosophy from the University of Notre Dame. His interests center on the application of virtue ethics to physician formation and clinical practice as well as on care and ethics at the end of life.

Farr A. Curlin, MD, is the Josiah C. Trent Professor of Medical Humanities in the Trent Center for Bioethics, Humanities and History of Medicine at Duke University in Durham, North Carolina. He is also an active palliative medicine physician and holds appointments in both the School of Medicine and the Divinity School, where he is working with colleagues to develop a new interdisciplinary community of scholarship and training focused on the intersection of theology, medicine, and culture. Dr. Curlin's empirical research describes variations in physicians' attitudes and clinical practices across a range of clinical domains, focusing particularly on the extent to which differences in physicians' practices are accounted for by differences in their religious characteristics, and his ethics scholarship engages moral questions raised by these religion-associated differences in physicians' practices.

John D. Yoon, MD, is an assistant professor of medicine at the University of Chicago and the assistant program director for the Internal Medicine Residency Program at Mercy Hospital & Medical Center in Chicago. He maintains a faculty affiliation with the University of Chicago's Program on Medicine and Religion, the MacLean Center of Clinical Medical Ethics, and the Bucksbaum Institute for Clinical Excellence. He is an academic hospitalist, clinical ethicist, and medical educator with research interests in the field of virtue ethics, moral psychology, and moral and professional formation in medical education.

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