QUADERNO

"LA RIFLESSIONE BIOETICA DI FRONTE ALLA CRISI PANDEMICA DEL COVID-19"
"THE BIOETHICAL REFLECTION FACING THE COVID-19 PANDEMIC CRISIS"

Two habits of the heart: a bridge-building proposal for professionalism, medical ethics and bioethics

Due "abiti del cuore": una proposta per costruire ponti tra la professionalità, l'etica medica e la bioetica

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This article begins by introducing the different interpretations and movements associated with professionalism, as well as their relationship with medical ethics and bioethics. It then formulates and presents a proposal linked to *virtue-based professionalism* in which, on the one hand, these three fields are reconciled and, on the other hand, medicine is able to preserve its identitarian goals, adapt to social and technological changes, and contribute to social progress. More concretely, it argues for the need to recover the heart of medicine, that is, to reincorporate its subjective dimension and learn to properly apply it to professional knowledge and practice. To achieve this objective, a three-stage training plan that inverts David T. Stern's pyramid is presented. In the first stage, doctors (current or future) learn to exercise the virtue of *sensory contemplation*– the first habit of the heart – at the patient's bedside.

Professionalism guides this eminently practical training step. The second stage explores the reasons behind professional ethics from the internal logic of medicine, a task for which the study of the history of medical thought is crucial. Here medical ethics plays a special role. Professional training culminates in the acquisition of the intellectual virtues that enable *intellectual contemplation*– the second habit of the heart. With it, doctors are able to decide what is truly best for each patient, assume responsibilities as a citizen and last, but not least, take on the practice of medicine with passion.

Bioethics introduces professionals to this third training stage, which typically occurs in the university setting.

Key words: Professionalism, Medical ethics, Bioethics, Sensory contemplation, Intellectual contemplation, Learning theory, Professional motivation, Medical training

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L'articolo analizza, in primo luogo, la professionalità medica contemporanea, nei suoi diversi movimenti e interpretazioni, nonché il suo rapporto con l'etica medica e la bioetica. In secondo luogo, viene formulata una proposta, collegata alla professionalità fondata sulle virtù, che, da un lato, armonizza i tre ambiti sopra citati e, dall'altro, rende la professione medica in grado di preservare i suoi scopi originari, adattandosi ai cambiamenti sociali e tecnologici e di collaborare al progresso sociale. Più specificamente, in questa proposta si sostiene la necessità di restituire il cuore alla medicina, cioè di riabilitare la dimensione soggettiva e di imparare a integrarla correttamente nella conoscenza e nell'agire professionale. Per raggiungere questo obiettivo, viene postulato un particolare progetto formativo a tre fasi in cui viene invertita la piramide professionale di David T. Stern. Nella prima, il medico impara a esercitare, al capezzale del paziente, la virtù della contemplazione sensoriale – il primo abito del cuore.

La professionalità guiderà questa fase di formazione eminentemente pratica. Nella seconda fase, verrebbero esplorate le ragioni dell'etica professionale entro la logica interna della medicina, un compito per il quale lo studio della storia del pensiero medico è fondamentale. Qui l'etica medica gioca un ruolo speciale. La formazione professionale culmina nell'acquisizione di quelle virtù intellettuali che consentono la contemplazione intellettuale – il secondo abito del cuore. Grazie a esso, il medico è in grado di decidere cosa è veramente meglio per ogni paziente, di assumersi le sue responsabilità come cittadino e, aspetto non meno importante, di fare della medicina una passione.

In questa terza fase formativa che è tipicamente universitaria, la bioetica riveste un ruolo prioritario.

***Parole chiave**: Professionalità, Etica medica, Bioetica, Contemplazione sensoriale, Contemplazione intellettuale, Motivazione professionale, Formazione medica*

"All theory is gray, my friend. But forever green is the tree of life".

[*Faust*. Johann Wolfgang von Goethe]

Two frameworks for professionalism

In 2018, the General Council of Medical Colleges (CGCOM for its initials in Spanish) of Spain, which coordinates and represents all the Official Medical Colleges at the state level, defined professionalism as the "set of ethical and deontological principles, values and behaviors that underpin the commitment of medical professionals to service to citizens, that evolve with social changes, and that guarantee the trust that the population has in doctors" (CGCOM, 2018, p. 17). In this formula, the study and dissemination of professionalism is based on two pillars: first, the defense of a series of ideals on professional excellence and, second, an express acceptance of the possibility of changing said ideals based on society's perception of medicine at all times, in all places and among all circumstances. The first pillar easily fits among the interests and tasks pertinent to medical education and bioethics and, before they existed, to ancient medical ethics, which included both. As Hamui and Ruiz point out, most definitions of professionalism "recall the fundamental principles of medical ethics, from Hippocrates, to discuss current situations that are unacceptable" (Hamui-Sutton, Ruiz-Pérez, 2017).

The second pillar, however, responds to a very particular interpretation of said ideals that veils a constructivist approach since the development and application of ethical principles as well as the principles themselves are subject to the evolution of time. These ideals are understood as historical rational constructions, that is to say, normative tools whose function is to enable moral behavior. Thus, professionalism (and the bioethical currents that support it) attaches particular weight to observation and analysis of the social moment and especially to the particular circumstances of each moral scenario in order to ultimately obtain consensus. This is to the detriment of a rational dialectic founded on immovable principles that welcome the growth of being as a natural reality, teleological entity, etc. In practical terms, one of the most significant signs of contemporary professionalism is found in the deep belief that, insofar as doctors' activity anchors them to the particular reality in which said conflicts take place, they can resolve conflicts, as well as identify the highest professional ideals. Indeed, on this view, doctors, together with other professionals, learn to avoid evil and to pursue the good at patients' bedsides rather than in medical school or by reading books.

Here we find the conundrum that this article aims to address. Is bioethics as an interdisciplinary field incapable of fulfilling its ends because of the emergence of professionalism movements? Does professionalism represent the covert rehabilitation of the ancient medical ethics that preceded bioethics? Today, new and old social imagery compete for primacy and, without a doubt, resolving this conflict will first bring significant change to professionals' sensibility and then impact patients as well. The matter therefore merits serious consideration.

To answer this double question, we must go back in time to better understand the origin of the professional movement. Three decades separate the CGCOM definition from the first conceptions of professionalism. At the end of the twentieth century, the *American Board of Internal Medicine* (ABIM) spread the term *professionalism*; until then, it was unusual to speak of "the force that drives doctors to do right by their patients no matter what" in bioethics forums

(ABIM, 1992). The ABIM outlined several pillars of professional ethics not as objective content, that is, pillars on which to do science, but as ideas that are depositories of the powerful force capable of moving doctors towards the most important values in their profession, like trust, respect, honesty, etc. In short, this initial version of professionalism seemed to be interested in addressing the subjective, experiential dimension of ideals that operate in doctors' mind, as well as in their hearts. From this new approach, analyzing values gives way to the integral transmission of these ideals, that is, it includes what makes them operationally desirable. Thus, the main question regarding professionalism is here formulated in terms of moral psychology. What is needed for doctors to internalize, understand, and know the essential values associated with their professional activity?

Facing the winds of change

Multiple factors led to the appearance of this first professional movement. The most important ones relate to technological advances, cultural changes and economic interests that, starting in the mid twentieth century, have, at best, blurred traditional medical practice and, at worst, undermined its deepest values. Catalysts for this transformation include the profession's hyper-specialization and the atomization of medical schools, a boom in scientific publications and new difficulties surrounding the avoidance of information overload, new legislation for patient rights and defensive medicine, qualitatively improved techniques for life support and organ transplantation, the social processes of medicalization, and the improvement of cosmetic medicine (Echarte, 2016). Today elements that seem to threaten the most traditional medical practices also include big data and artificial intelligence in clinical practice. They prompt questions like whether machines will be able to replace radiologists or surgeons or if being human presents any added value. It is understandable that, even today, health professionals sense that their ways of working are threatened, especially when new scenarios force upon them tasks that have little or nothing to do with their initial vocational choice.

Faced with these circumstances, medical professionalism emerged to safeguard what is essential to medical activity. As was the case in the Hippocratic school, it implies the ability to incorporate technological changes, i.e., new and better ways of healing and caring, without giving up the profession's ends. In effect, the Hippocratic-Aristotelian conception of health and medicine has been present in university faculties practically since their origin and is still manifested today, even if only in an ornamental way, in the oath that medical students take when they finish their studies. It is no coincidence that the term *force* appears in the ABIM's brief definition of professionalism, a term that is key to Aristotle's theory of virtue, which is the basis of his entire ethics. I will address this matter in detail later, but, before that, two other factors that have driven the professional movement must be discussed.

The emergence and development of bioethics, especially since the 1980s, is a second explanatory factor that is also closely connected with the previous one. The development and transformation of medicine brought with it innumerable new problems that seemed to demand a robust interdisciplinary approach, and thus gave rise to bioethics. Therein, philosophers, jurists, economists, and sociologists, among others, came to the aid of medical ethics, which prior to that moment primarily received contributions from doctors (Rhodes, 2002; Washburn, 2008). However, some of these invitees did more than seek new solutions to new problems and instead began to rethink and question the theoretical foundations of the profession. This is the case, for example, of the classic concept of nature, a central point in the semantic connection between the concept of health and the good, which was, until then, discussed outside the medical field rather than within it.

The most noteworthy example of this conceptual revolution in medical ethics is found in *Principles of Biomedical Ethics*; first published in 1979, it was authored by the philosopher Tom L. Beauchamp and the philosopher and theologian James F. Childress. Considered a classic text among health professionals – and, for many of them, the main consultation manual on professional ethics – its eighth edition was released in 2019. In general terms, in this work, the Hippocratic-Aristotelian approach to ethics is displaced by *principlism*, a modern and very particular version of Kantianism. Principlism proposes four principles as the basis for solving the new (as well as old) problems of medical ethics, including non-maleficence, beneficence, autonomy and justice. The success of this publication – and of principlism itself – lies in its apparent simplicity. In the first place, it is based on what most human beings recognize as good. In addition, it proposes dialogue as a method, an element that is to the liking of Western citizens with democratic sensibilities. Thus, it dispenses with everything else, especially subtle theories that require patient training. In the second place and disenchanted with metaphysics, it implicitly assumes many of the materialistic postulates of the time, including the reduction of nature to inert clay. Its attempt to reconcile freedom and nature gave way to the search for how to reconcile freedom between individuals. Again, for those who do not think much (or for those who can only think about one thing), molding this clay towards individual and collective interests is seen as a less complex and laborious task than trying to decipher the place and end of every single thing in the universe.

The liberation of medicine from obsolete beliefs, traditions and codes resulted in a further weakening of its aims and boundaries. Paraphrasing Zygmunt Bauman, the triumph of principlist bioethics (today one could almost say, sans adjectives, bioethics), has made medicine, already in-

fluenced by its context, even more liquid. On the one hand, its principles of obligation are not absolute (Degrazia, 1992) and, on the other hand, the principle of autonomy (respect for autonomy, as formulated in the latest editions of the *Principles of Biomedical Ethics*) ends up prevailing in the resolution of ethical dilemmas (Solís García del Pozo, 2018). This covert autonomism, in which the doctor-patient relationship is practically reduced to a negotiation of wills, has led not a few professionals to seek refuge in movements that try to restore objectivity to bioethics and honor professional opinion. Some have proposed new interpretive pathways for bioethics, while others advocate for a return to medical ethics. In addition, for almost a decade now, more and more have begun to see professionalism as their lifeline.

After almost half a century, bioethics may seem too impregnated with autonomism for it to change course, while medical ethics has justly or unjustly earned a reputation for being retrograde, which has weighed it down so much that taking up its flag again seems impossible. Professionalism thus seems like the only viable third way.

Competencies in the humanities

The third factor that helps explain the emergence and evolution of the professional movement is found in the rise of new pedagogical approaches that, at the end of the twentieth century, aimed to improve the connection between educational centers and social labor demands. This phenomenon began in the United States in prestigious universities, but soon spread to Europe with the so-called Bologna Process (Brunner, 2009), which focused curriculum development toward competence acquisition. The resulting study plans focus on identification and transmission of content as well as of professional skills and attitudes. In the case of medical school, a competency-based education presents some challenges, as Hayley Croft et al. point out, including knowing how to anchor training generalizations in specific, concrete and measurable behaviors (Hayley Croft et al., 2019). Previously, universities almost exclusively regulated medical education and teaching scientific-technical skills –in the classroom, in the laboratory, or in hospital internships– such that educational changes were mainly formal. The same cannot be said for the transmission of humanistic values since, traditionally, professional ethics was taught as a theoretical subject at the master's level. Of course, students were supposed to learn the ideals of medicine during their internships by observing and imitating their medical tutor, but this type of ethical-educational interaction was not usually explicitly integrated into teaching planning, nor was it systematically evaluated during practices. In the face of the challenges associated with competency-based education, the professional movement came to the rescue, which, as mentioned, had undergone discourse development for two decades.

Until then, the initial professional movement was concerned with identifying and defending the traits that characterize and move a good doctor; it thus naturally paired with educational tasks related to medical humanism. However, two circumstances conditioned this approach. In the first place, with the aforementioned rejection of old philosophical reasoning, new constructionism, as well as approaches that came from outside the guild, did not result in solid alternative foundations, and were rather superficial and sometimes puerile. As a consequence, misuse of rhetoric, fallacies (especially the *argumentum ad verecundiam* or authority), the establishment and support of lobbies, and excessive use of pedagogical materials to appeal to students' feelings (films, testimonies, etc.) became hard to resist temptations for many of the once well-intentioned advocates of classical professionalism. Second, new competency demands to objectify and measure learning outcomes forced professionalism to make behavioral commitments that were not present in its earlier formulations. In the absence of a solid conceptual and methodological apparatus regarding the ends of medicine, the temptation to reduce education in medical ideals to the simple art of observation and imitation of behavior has come to represent a third, equally seductive temptation.

Faced with this panorama, criticism has never been lacking since mere performance is always suspected of simulation and is, therefore, fragile, futile and sterile in ever-changing medical scenarios. Worse still, imitation, abandoned to its fate, usually leads to fanaticism and the stalest of sectarianisms. They are poisoned fruits, which not a few end up disavowing and surrendering to the opposite position (Kirk, 2007; Hanna & Fins 2006; Jarvis-Selinger, Pratt & Regehr, 2012). For many of these critics, including the author of this article, if classical professionalism wants to be useful and survive, it must return to its origins and promote and work towards something that may not be entirely evaluable from an objective point of view, that is to say, to the source of all initial vocational movements and of all ultimate aspirations towards the good. How can this be achieved? Before answering this question, it is necessary to consider other factors proper to the contemporary context in which medicine is immersed.

The autonomists' response

The scenario became even more complex when, at the beginning of the century, the prevailing bioethical movement, autonomist bioethics, began to take interest in the teaching approaches developed in professionalism. The simultaneous 2002 publication of the article "Medical Professionalism in the New Millennium: a Physician Charter" in the *Lancet* and *Annals of Internal Medicine* journals represented the first milestone of this overlap. With it, a new sort of professionalism was born, immediately achieving heightened visibility

among health professionals. The aforementioned publication presented the *Medical Professionalism Project* and, although it had the participation of the *ABIM*, the weight of the *ACP-ASIM Foundation* (American College of Physicians- American Society of Internal Medicine) and the *European Federation of Internal Medicine* was decisive for this principlist turn. In the introduction of this article, professionalism is defined as "the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession" (Project of the ABIM Foundation, et al., 2002). In these lines, we find the central guidelines associated with the definition of professionalism that a majority of medical colleges have assumed, including, among others, the CGCOM.

In short, the classical professionalist movement was spurred on by, on the one hand, a loss of the medical identity and, on the other hand, the promise that the principlist approach would return professionals to their proper responsibilities. This promise weakened with the Medical Professionalism Project's new version of professionalism, which is characterized by its inclusion of the social contract, of principles, and of public trust in physicians. In effect, these elements are obvious winks at a constructivist conception of medicine that, as mentioned, revolves around the establishment of consensus, including on what the profession can be or become. Proof of this is found in the section following the introduction, which is dedicated to three of the four principles enunciated in initial principlism– the principle of non-maleficence has long been imbued with that of beneficence. The question then emerges as to what is peculiar to professionalism with regard to bioethics. A brief answer points us to *know-how*. If bioethics examines the end of medicine, i.e., the good of the patient, professionalism takes care of providing doctors with the knowledge, and helps them acquire the requisite competencies, to achieve said end. The last section of the article that outlines the *Medical Professionalism Project* addresses the responsibilities in which medical professionals should receive training, including in professional competence, honesty and confidentiality, in avoiding inappropriate relationships with patients, in improving quality of care and access to care, in facilitating the fair distribution of resources, in promoting the advancement of scientific knowledge, in maintaining trust through the proper management of conflicts of interest and in self-monitoring.

It must be noted that, as we will see below, these ten recommendations, which purport to be practical, continue to be entirely formal proposals since, with an autonomist foundation, it is impossible to identify more concrete content without getting into the specifics of every single medical case. How far does honesty or confidentiality go? And more importantly, what does the fair distribution of resources or the proper promotion of scientific knowledge mean? For principlism, professionals, in dialogue with individuals in each context, must give them (1) meaning and (2) abstract limits that should not be extrapolated to the whole medical community.

Varieties of professionalism

With the panorama described above, it is easy to understand why a great diversity of currents has emerged from the initial version of professionalism. And this is even more so given the communication channels that now exist among all of them and that have multiplied, with intermediate positions, the definitions of professionalism. Despite this, it is possible to identify two broad groups in terms of content, including professionalisms that are presented as an alternative to bioethics and those that are constituted as part of it, i.e., a practical-teaching version. The fact that the former group also encompasses the competence dimension of ethics may seem confusing. On the other hand, using interpretative criteria, these two groups usually correspond to the anti-autonomist and pro-autonomist groups, respectively, although not always or not entirely, especially in countries of Western influence where medical sensibility still tends toward old school directives.

This is seen with particular clarity in Do-Kyong Kim's *Medical Professionalism in Neoliberalism*. Kim, who teaches within the Department of Medical Humanities at Dong-A University in South Korea, relies on the definition from the *Medical Professionalism Project* and criticizes classical professionalism for not responding to the winds of change, which are increasingly influenced by neoliberalism and commercialism and which are transforming the demand for healthcare services. "Patients seek the help of doctors to attain healthier and more beautiful bodies as well as to treat diseases" (Kim, 2019). He argues that if doctors do not respond to new consumption habits – that is, to new market needs, which also affect understandings of health and illness – then trust in health professionals will decline, which "will only elevate the skeptical attitude of doctors towards professionalism as a simple symbolic slogan. Professionalism should be feasible" (Kim, 2019). For Kim, professionalism– autonomist professionalism – will fail in its attempt to safeguard the medical identity and will bar the profession from evolving along with society if it is inconsistent with its ideology.

Kim assumes the autonomist ideology of Western bioethics and of this new version of professionalism. However, he urgently suggests that it avoid the overtones and scruples of a sensibility that is not yet completely liberated from out-of-date worldviews. Even more significant is the fact that he

does not present a new professionalism, but gives voice to a type of professionalism called *business professionalism*, which was formulated a decade ago far from South Korea or any Eastern country by Brian Castellani and Frederic W. Hafferty, who work at the University of Kent and the University of Minnesota-Duluth, respectively. This professionalism characteristically prioritizes the autonomy of the patient, the free market, and professionals' scientific and technical knowledge to the detriment of altruism and social justice (Castellani and Hafferty, 2006). Business professionalism does not fall into radical neoliberalism because it does not renounce benevolence and compassion in healthcare, but it does invert the classic scale of professional values and sees benevolence as expendable.

Kim's interpretation of the medical professional crisis brings a point of clarity to this discussion. The experiences of professional alienation that catalyzed the professional movement are more linked to doctors' indecision about preserving old ideals or embracing new ones than to an onslaught of change. Preserving the medical identity implies, in one sense or another, a choice, which is precisely what Westerners seem to be avoiding in their reluctance to give up the sensibility associated with the past. Whatever the solution to this dilemma, the problem of professionalism is now sufficiently laid out.

This formulation of the Western identity crisis has been reinforced in recent years by scientific research on professionalism and interculturality. All of it points to the fact that the values that define the medical profession change between cultures and generations much more than expected (Jha et al., 2015). One good example of this research came out of the University of California in collaboration with various Thai medical and university centers. The researchers analyzed the consensus on the definition of medical professionalism in four generations of emergency physicians. Their conclusions claim that a certain consensus is recognizable among professionals, but not between different generations of patient groups (Hoonpongsimanont et al., 2018). As expected, with society's evolution, confidence in medical professionals regarding their services, delivery thereof and what they should be varies significantly. In a second relevant article, Al-Rumayyan et al. compare three frameworks of professionalism in non-Western countries and reach similar conclusions: "There is no single framework on professionalism that can be globally acknowledged" Al-Rumayyan et al., 2017). Both time and place introduce decisive factors for understanding what a profession is and the consequences of it revolving around social demand.

Are there as many versions of professionalism as there are cultures or ways of feeling? And more importantly, should doctors adapt to each of them? A positive answer is the most coherent position from the point of view of principlist bioethics. The promise of a *minimum ethic* shared by all doctors and patients on this planet is usually met with the hegemony of the principle of autonomy, which, for the most consequential principlism, is the only true ideal with which one must learn to live. This applies to Kim and his belief that doctors should accept their profession as a mere social construction, thus preventing them from anchoring behavior in anything beyond social circumstances.

The pyramid of excellence

Despite clamors from the East, it will take years for Western advocates of principlism to convince themselves that doctors in different societies need not have anything in common, at least in terms of the purposes of their activity. The pursuit of a *minimum ethic* across generations and cultures will continue to be an ideal in our universities and hospitals for some time, which explains the spread of a belief that has been gaining strength over the past two decades among many doctors. It supposes that if, in the West, bioethics, like ethics in general (with an autonomous character, of course), is concerned with the lowest common denominators that every doctor must meet instead of professional excellence as such, then who is in charge of monitoring such an ideal? It is worth recalling that the pursuit of excellence is what makes doctors feel most proud and fulfilled, and what often attracts them to the profession. Some have looked to professionalism for the answer to their concerns about the highest standards of professional activity (Irvin, 2012). However, given the theoretical framework in which this professionalism of excellence has emerged, it is unlikely that a single model will be sufficiently accepted among professionals, thus imperiling its consolidation. The opposite seems more likely, that is, that the number of professionalist proposals will increase so much and in such a diverse way that they end up stifling one another. The professionalism of excellence seems doomed to lead, like all ethics of minimums, to the entrepreneurial professionalism of Castellani and Hafferty.

The idea of professionalism as a project dedicated to medical excellence has received support not only on a professional level, but also on a competency level, that is, as a curricular strategy. One of the most influential works on the competence turn in American university curricula, as discussed above, came from David T. Stern's framework for measuring professionalism. It places professionalism at the apex of the pyramid of skills that a medical student should acquire while studying her degree. The base contains clinical competences, then communication skills, then ethical and legal understanding of clinical scenarios and, finally, supported by the four pillars of excellence, humanism, responsibility and altruism, professionalism represents the integrated summit of them all (Stern, 2006). Numerous university hospitals use this structure to transmit ethical content including, among others, the prestigious Mayo Clinic (USA), which has made Stern's professional framework especially visible.

Stern's logic around professionalism and excellence is founded on the assumption that, only when students have a sufficient scientific-technical base and only if they have acquired sufficient communication skills to understand and make themselves understood with patients, can they consider the ethical dimension of the job. It is especially significant that the ethical and legal dimensions are placed in parallel, which reflects a certain comparison between two fields that, at least in their classical conception, although related, have a qualitatively different purpose and methodology. The law aspires to social coexistence and, at best, employs consensus-achieving methods, while ethics pursues knowledge of the good, which requires the use of reason.

In this light, ethics aspires to objectivity of the given, while law is always built starting from the most common practices that make up communities. This explains why the law may not be fair and the exercise of a good may be illegal. As Aristotle argued long ago, the more stable a society, the more it is possible to interchange ideas; dialogue begets wisdom, better social practices and, ultimately, better laws. The opposite is also true. The less rational people are, the more unstable their coexistence models are (Serrano, 2005). Of course, this thesis has incited extensive controversy. One of its best known detractors, Aldous Huxley, linked this thesis with scientific-technological development and suggested, in the *Prologue* of his most famous novel, *A Brave New World* (Huxley, 2013), that a society can be very stable and, at the same time, perverse. Conversely, his latest novel, *Island* (Huxley, 2006), exemplifies a beautiful, fair, good society that is nonetheless doomed to collapse based on perverse, external circumstances. If Huxley is right, not all kinds of stability lead to dialogue and, ultimately, wisdom.

Leaving this controversy aside and returning to Stern's scheme, the logic of locating the ethical and the legal on the same plane entails, to a large extent, an autonomist conception of ethics and, therefore, leads to assigning the same method to ethics and the establishment of laws. Herein, the difference between the two is found in that the law takes care of the lowest common denominator of a community's goals to prevent the suffocation often associated with coexistence, while ethics protects and promotes other social behaviors more flexibly (Moreno, 1995). We thus arrive at the crux of this section – this upward dynamic permeates not only the bridge between politics and ethics, but also between ethics–ideals of mandatory compliance – and professionalism – ideals that demand free accession.

Autonomous professionalism of excellence faces, like bioethics itself, the stumbling block of implementation. In 2009, Paul S. Mueller, a member of the *Division of General Internal Medicine and Program in Professionalism and Bioethics* at *Mayo Clinic*, asked the following about this challenge: "Excellence, humanism, accountability and altruism… how does one teach abstract concepts such as these?" (Mueller, 2009). In his response, he advocates for the use of experiential audiovisual materials on professional and non-professional conduct and for interactive activities such as case discussion, role-playing and simulation, team learning, narrative writing, etc. In contrast, little space is given to the Stern framework or even to theoretical reflection on the reason for these ideals. Theory is relegated to the background, which presents not a small problem because, however noble the values of the medical community that receives new students, once graduated, new professionals venture into new settings with different, even opposing, sensibilities and their corresponding narratives and slogans. It follows that students would try to safeguard their identity as physicians by choosing similar moral niches for their professional activity, which leads to the inevitable intensification of the experience of professional and moral feudalization. Nothing attracts relativism more than this situation. After having suffered from the decline of objective morality and the relaxation of practices for several generations, professionals have begun to experience burnout, which is now typical of the field and usually accompanied by the most cynical disregard for social conventions, whether minimum or maximum.

The return of virtue and nature

The serious problems associated with professionalism of excellence have not gone unnoticed by medical school professors. Many of them have lowered the professionalist ideal to what is affordable and measurable with relative rigor, specifically, good conduct and professional codes. Two professionalisms have emerged in this breeding ground. The first one, using David M. Irby and Stanley J. Hamstra's nomenclature, is called *behavior-based professionalism* and mainly focuses on professional aspects that are manifest and independent of inner attitudes or group recognition. The second one is called *professional identity formation*, which is in tune with the consolidation and feudalization of the sensibility niches described above. In this group we could include, for example, the definition of Medical Professionalism touted by the *American Board of Medical Specialties*, one of the largest doctor-led organizations of its kind: "A belief system in which group members ('professionals') declare ('profess') to each other and the public the shared competency standards and ethical values they promise to uphold in their work and what the public and individual patients can and should expect from medical professionals" (ABMS, 2018). The expression "belief system" is not trivial and refers to the ideas one assumes that constitute the self – to a represented identity. Because the moral agent is consolidated in such system, moral reflection outside of its limits is always very difficult, tiresome, and involves overcoming the ever-present ideological character of the self (Echarte et al., 2016).

The Irby and Hamstra classification also includes a third type called *virtue-based professionalism*, which focuses "on

the inner habits of the heart, the development of moral character and reasoning, plus humanistic qualities of caring and compassion" (Irby and Hamstra, 2016). This third proposal rescues the notion of virtue and, with it, an ancient tradition about the good and human action. As mentioned, this tradition served as a theoretical framework in medicine for centuries. Here, it resurfaces as a proposal to reunite three worlds – that of the objective and the subjective, the social and individual, and action and contemplation. Professionalism based on virtue also offers a suggestive and integral vision of the relationship between ethics and professionalism. Finally, this professionalism may help many doctors – including those who defend the most traditional medical ethics – who have had to set aside the interpretative framework that gives their behavior meaning and have thus reduced ethics to procedural recommendations.

It is impossible to apply the Aristotelian theory of character without rooting it in its corresponding conception of nature, that is, if one wants to avoid (1) the criticisms of its detractors, (2) adverse social sensibilities and climates and (3), most importantly, disenchantment from students and professionals who aspire to virtue with intellectual honesty. For Aristotle, natural beings contain a principle of movement and rest "whether in respect of place, or growth and decay, or alteration. A bed, on the other hand, or a coat, or anything else of that sort, considered as satisfying such a description, and in so far as it is the outcome of art, has no innate tendency to change" (Aristotle, *Physics II*, 1, 192b, 10-15; 1979, p. 23). Natural things, therefore, have an intrinsic purpose by which they are driven, which is, in addition, based on their position, state, time, etc. In contrast, artificial things have an external end that is given to them by their architect. A third group of things has no purpose; for Aristotle, they are (1) unconditionally necessary phenomena (they have no purpose, but cannot be otherwise), for example, the eclipses of the sun, and (2) fortuitous events (which have no purpose either, but cannot be otherwise), for example, forest fires. Non-teleological phenomena do not require an explanation since answering the question of "why" leaves us with a) because it is so (necessary processes) or b) that is a nonsensical question (random processes). Thus, intelligence only deals with teleological and artificial phenomena, those to which it can give a meaningful answer.

The Aristotelian idea of natural good, i.e., the end toward which each natural object moves and its corresponding place in the universe, takes on meaning here. By contrast, the good is absent from necessary, accidental or violent movements, while artificial goods depend on the architect's interest(s) rather than on what is produced. However, the origin of artificial ends – the architect's intelligence – is easily detectable, but natural ends are more difficult to apprehend. Aristotle proposes a method that has been crucial in the history of thought. "Spiders, ants, and the like have led people to wonder how they accomplish what they do, if not by mind. Descend a little further, and you will find things coming to be which conduce to an end even in plants, for instance leaves for the protection of fruit. If, then, the swallow's act in making its nest is both due to nature and for something, and the spider's in making its web, and the plant's in producing leaves for its fruit, and roots not up but down for nourishment, plainly this sort of cause is present in things which are and come to be due to nature. And since nature is twofold, nature as matter and nature as form, and the latter is an end, and everything else is for the end, the cause as that for which must be the latter" (Ibid., 8, 199a, 20-30; 1979, pp. 40-41). Aristotle thus arrives at the notion of final cause as an operative end from which growth is possible (the soul of things that encourages them for their good), which does not require, as presented here, the intelligence of what is preached or, at least, the kind of intelligence that contemporary biology holds as valid. Of course, the presence of intelligence, and of rational intelligence in human beings, is a sign of a final cause of a special nature. It is so special that it ultimately indicates that something in said natural object persists after death. In addition, Aristotle attributes divine origin to that something and affirms that human beings deserve particular respect among natural beings based on it.

Aristotle's general framework is quasi-anthropocentric since, on the one hand, man is granted a special ethical status but, on the other, the good appears here as transcendental and is hidden in more things than we suppose, including in rational animals, in the sentient, in the members of the vegetable kingdom, as well as in many inert beings. The natural world is populated by beings with souls, beings in whose depths wonder is hidden because natural goods manifest the most exquisite of all beauty. As we will see it in the next section, it is against this background where all pedagogy and acquisition of ethical competences would have to begin.

The great machine

Based on the theoretical framework presented in the previous section, any transformation that has the potential to distance medicine from its service to the natural good, whether intentional or not, individual or collective, is disastrous since the natural good is considered an objective reality internal to things rather than a construct. However, today those who consider themselves detractors of said autonomism, i.e., those who defend traditional medical ethics and virtue-based professionalism, assume both explicitly and implicitly important ideas forged in contemporary autonomism. In what follows, we briefly review some of them.

Since the dawn of modernity, the classical idea of nature has been reduced, on the one hand, to that sort of human nature and, on the other, has been associated with the conventional notion of intelligence. René Descartes is largely to blame for this double twist; in his metaphysical proposal, he

deteleologizes all reality except for human reality. The world is thus turned into an enormous machine fixed on ends that come from outside of it, from the Creator, *the great watchmaker*. "With this," Robert Spaemann writes, "teleology is drawn out of nature and placed with God's spirit" (Spaemann, 1978). Second, Descartes associates the soul with the thinking part of man, the *res cogitans*. Thus, without consciousness, ends cease to exist. Finally, Descartes proclaims substantive independence between the world of matter and the world of the spirit, which, in practical terms, also implies certain methodological independence in his approach to both worlds.

The philosophical drift that Descartes initiated with the deteleologization of nature necessarily ends, according to Spaemann, in the *deteleologization* of human beings (Spaemann, 1978). And indeed, new philosophies began to emerge from the Cartesian rupture. Kantianism, to which principlist autonomism is heir, is among the most important. Therein, the soul, as a given source of finality, is replaced by the rational will– i.e., the creative source of ends. Of course, this drift has also directly affected the way of doing experimental science. "Nature is what we have not done. But we can only do something because nature itself constitutes a kind of material that is already informed, and so we can understand it in analogy with what we do. And precisely because nature is not mere passive matter, Aristotle in turn distinguishes between natural and violent motion, a distinction whose disregard belongs to the fundamental premises of modern physics" (Spaemann, 1978). This Cartesian split and its attendant deteleologization have especially impacted the medical profession, dividing medicine into two kinds of disciplines, namely those ruled by physical causes, and those ruled by the mind. Within this paradigm, it is only possible to seek meaning and purpose in the latter psychological dimension. At the same time, this split has forged a new ethical sensibility in which the body, as an inert and indolent ship, must follow the course set by a pilot who would rather not listen his ship's voice, much less dialogue with it.

The classical professional movement was in part fostered, as mentioned above, by many physicians' desire to preserve traditional medical values without the baggage of traditional metaphysics. Now it is clear to see what this effort intended to leave behind. First, as Spaemann laments, traditional ideals were refounded on human possession of rationality and/or his status as a creature of divine design. The idea of the existence of a final cause, which is also present in other realities and makes them worthy of respect, today engenders more scandal than praise. *Laudato Si*, Pope Francis's 2015 encyclical, has been a real wake-up call regarding this forgetfulness. It is still too early to foresee the effects of this text among Catholic doctors who work in medical ethics and professionalism, but, optimistically, it might be an important step in eliminating the prejudice that sees, in general, returning mystery to nature as weakening the dignity of human nature. On the contrary, competently opening human ethics to natural ethics would rehabilitate one of the most powerful arguments for the existence of good and evil. On the contrary, rejecting the teleological and aesthetic dimensions in the natural world implies accepting the presuppositions that empower autonomist arguments.

This is not merely a theoretical matter. Learning to contemplate reality in all of its richness, and to make a habit of said contemplation, is a fundamental way for doctors to develop sensitivity and ethical rationality. This issue is as important as it is absent in the vast majority of medical teaching plans, including medical ethics and classical professionalism. Further discussion of this matter goes beyond the confines of this contribution, however, it is worth mentioning a class I have been teaching since 2017 called *Science and Literature* at the University of Navarra's School of Medicine. It first aims to teach students to see the world as great artists have captured it in their works. Its second, subordinate aim is to encourage them to apply this gaze to their profession on a regular basis, that is, to become artists in a world that itself is artistic.

Interdisciplinarity: between the particular *physis* and the universal *physis*

Another Cartesian idea that medical ethics has adopted pertains to methodological independence. Modern medicine has been closing in on itself and on its methodological fields to the point that accusations of interference abound today even among the medical specialties themselves. In fact, the origin of bioethics is usually presented as an interdisciplinary response that, on the one hand, is necessary based on the changes derived from contemporary scientific-technological development and, on the other, as an alternative to a medical ethics too stuck on tradition and unable to integrate discourses that are unaware of the profession's internal logic.

There are several reasons to argue that, despite this, interdisciplinarity has its limits and that, therefore, bioethics should be seen not as improvement, but rather as a natural extension of medical ethics. Some of these reasons are very old. The Hippocratic tradition, for example, presents the problem of the limits associated with the related fields of study. The Spanish anthropologist Pedro Laín Entralgo identified three well-defined positions in the *Corpus Hippocraticum* as follows: a) Philosophy as the express foundation of medicine; 2) discussion of prevailing philosophical knowledge based on professional observations; and 3) "those who try to separate medicine as a field of knowledge from philosophy" (Laín Entralgo, 1972). However, this third position must be adequately contextualized. It certainly renounces founding medicine on a speculative hypothesis (specifically, belief in the existence of a *Nous* to which everything is directly subjected), which was characteristic of Apollonian-

inspired medical schools and with which the Asclepius Hippocratic School intended to break. Ultimately, the starting point of medicine should adhere to "experience, healthy reflection and 'bodily sensation.' These elements instruct us in 'the beginning and the way' of the art of healing and in man's true nature. This approach seems to argue for pure empiricism and medicine's complete independence from philosophy" (Idem). However, Laín Entralgo adds, "a careful examination of the text reveals that its author intends to arrive at a philosophy (of man) based exclusively on medicine, rather than to practice medicine without philosophy" (Idem). It is not entirely accurate, therefore, to affirm that this new idea of medicine originated entirely in medical experience since a double speculative hypothesis supported the pillars of this third alternative, as we explore in what follows.

The first hypothesis recognizes the existence of a particular *physis*, a nature that justifies appealing to the proper reason that each thing possesses. Laín Entralgo enumerates some of them: "The stars, the parts of the world, the winds, the waters, food, medicines, man as such – the human *physis*–, the body, the soul, the different parts of the body, each human individual, the various characteristic ways of being man, diseases, animals"(Idem). Doctors are thus tasked with familiarizing themselves with the rational principle of the body, which is possible by way of each thing's *dynamis* or virtue, namely "the power or capacity of a thing to show what it is: whinny and green, for example, are *dynameis* proper to horses and grass"(Idem). In this context, doctors must devote their lives to the human organism's *physis*, which is revealed in particular pieces of evidence that come into focus for those who know where to look, rather than by way of knowledge of the *Nous*, understood as the deepest soul that underlies each thing and in which everything shares.

This maxim can be sifted with the second speculative hypothesis, namely a belief in a universal *physis* that explains the harmony among all particular *physes*. Just as doctors must understand the proportions and relationships that exist among the body's different organs, they must also keep in mind those that the body maintains with the rest of the natural realities. For Laín Entralgo, doctors in ancient Greece aimed at "love of universal nature, as realized in each man's individual nature (in accordance with the root of the Platonic and Aristotelian theory of friendship)... As Plato says, 'the patient is the friend of the physician because of disease, and for the sake of the health…' It is no coincidence that the Greek mythical imagination attributed the invention of medicine to a god" (Lysis, 2017a). This aim begins in the body and ends in something that is outside of the body; the body is a herald and a reflection of it and it powerfully drives doctors' lives. Thus, it is not an abandonment of the study of the body, but rather, thanks to knowledge of its relationship with the whole as *kósmos*, physicians can discover the profound beauty that the body hides within it. The ultimate meaning of the medical vocation springs from an aesthetic relationship.

In applying the above framework to the initial discussion, bioethics appears as the catalyst of medical ethics and, consequently, they do not maintain a symmetrical relationship since the former makes sense without the latter, but not vice versa – no matter how noble the latter's ends may be. This is precisely one of the great evils attributed to contemporary bioethics, namely its uprooting accelerates the destruction of what is essential to the medical profession, a phenomenon that goes hand in hand with forgetting the *physis* or the reason proper to the human body. This idealism, to which most interdisciplinary and principlist bioethics seems to have succumbed not only does not intensify the light in doctors' hearts (because it degrades the study of the particular *physis*), but it also makes said light sterile by reorienting professionals' gaze from the human body to particular agents' autonomy.

The alternative presented by the classical professionalist movement recovers the importance of the particular physis, but at the cost of undervaluing the universal *physis*. With this, post-Cartesian ethics and all of its ills are resurrected in an ethics closed in on itself and at risk of losing even the advantages that it brings, in particular, an appealing rationality that integrates and governs the body as a whole. Harmony in the particular *physis* – sometimes called *substance* – is consolidated and nourished by a bigger *physis* of which it is a reflection. Ignoring this subjective impulse means condemning the study of the body to a progressive and destructive process of homogenizing atomization. The cycle is closed here because, in this process, the particular *physis* also succumbs to blind and violent causes that cover it so thoroughly that it ends up accounting for the entire reality – i.e., the same information applies to both the human body and to the most distant star. These forces have little or nothing to do with the classical *Nous* or with the universal *physis*.

Far from being a prediction, the drift of medical ethics can be recognized as history because, let us recall, its worst fruits (closure, elitism and monopoly) gave rise to contemporary bioethics in a rebound effect.

Health, happiness and universal good

In rehabilitating the axiomatic and hierarchical relationship between the particular and universal *physis*, we find a way out of the sterile dispute that classical professionalism and autonomism have maintained for decades. In addition, it entails mutual recognition between medical ethics – including new professionalism – as an entity associated with the study of the particular *physis* and bioethics – seen as a method with an interdisciplinary approach of a purely objective nature.

"The professional ethos of physicians," Sabine Sallock writes, "must be differentiated from the perspective of ethics which can take a universal standpoint and has the potential to critically assess context-specific moral norms." (Sallock, 2016). The challenge is found in figuring out how the two are related. The *ethos* of medicine involves the particular human body, but the norms that constitute it are not conjunctural or circumstantial. The same goes for any scientific field insofar as it addresses the inner reason of the objects that constitute it and, at the same time, seeks interdisciplinary dialogue given that such reason reveals to scientists an intimate alterity with the other, and with the whole – the *elan* of the universe.

The delicate relationship between both *physes* is especially important in fields expressly dedicated to the study and practice of the good. Medical ethics falls within that description since its end and good correspond to patient health and care. These particular human affairs, however, must be integrated with other goods for the attainment of happiness – the superior and ultimate good. Indeed, just as the good of the body transcends the body itself, the norms that govern the body reach beyond the body. Otherwise, any claim to objectivity would be futile, and the opposite is also true. That the medical ethos is capable of objective analysis does not lead to the conclusion that it can be classified as a science *stricto sensu*. As Aristotle pointed out long ago, no ethics, including medical ethics – indeed, no search for knowledge about the good, be it particular or not – can be classified as pure science or *episteme*. Medicine is an art (*techné*) because its ultimate goal is to care for the sick on the particular level, rather than to reach universal truths. Similarly, medical ethics is the study of the end/good associated with said art. Thus, it seeks a particular good based on two considerations, namely it does not refer to the good of the universe or to the general good of man.

Health, like pleasure, wealth, honor, etc., is subordinate to a greater good, namely human happiness, which is, in turn, subordinate to an ultimate good. Aristotle says, in likely reference to the ideas of his teacher Plato, that said ultimate good "is good in itself and causes the goodness of all these as well" (Aristotle, *Nicomachean Ethics* Book I, Chapter IV, 1095a, 25-30, p. 5). Knowledge of the two goods above health cannot be accessed through the art of medicine as such, but is reached, Aristotle further argues, with the acquisition of prudence (practical wisdom), an intellectual virtue with which we are able to understand what is most fitting for each situation. As he notes, "Now it is thought to be a mark of a man of practical wisdom to be able to deliberate well about what is good and expedient for himself, no in some particular respect, e.g. about sorts of things conduce to health or to strength, but about what sorts of thing conduce to the good life in general. This is shown by the fact that we credit men with practical wisdom in some particular respect when they have calculated well with a view to some good end which is one of those that are not the object of any art. It follows that in the general sense also the man who is capable of deliberating has practical wisdom" (Ibid., Book VI, chapter V, 140a-b, p. 142). Numerous goods compete in most daily human deliberations on what is best, not in one respect or another, but, in general, in what suits the individual and, even more generally, in terms of the good of the universe. In the Aristotelian framework, a reckless doctor is seen as one who forgets her patient's general good and sticks to limited activity that, in the end and for this very reason, starts to become perverse. Again, medical ethics and bioethics appear here in their noblest, most symmetrical and mutually necessary relationship. In addition, Aristotelian theory on the knowledge of the good also provides us with new light regarding the stages and periods of learning, which can be helpful in physician training, as we explore below.

Aristotelian prudence is an intellectual virtue and the key to moral thought, which, without being either, draws from both practical experience – art – and the most speculative of activities – science. "Therefore, since scientific knowledge involve demonstration, but there is no demonstration of things whose first principle are variable (for all such thing might actually be otherwise), and since it is impossible to deliberate about things that are of necessity, practical wisdom cannot be scientific knowledge or art; not since because that which can be done is capable of being otherwise, not art because action and making are different kinds of thing" (Idem). Experience is required, of course, because human beings cannot apprehend the principles of morality without it (for example, that good must be done and evil refrained from) – a type of quasi-intuitive knowledge (the Aristotelian *epagoge*) whose acquisition the Scholastics assigned to *synderesis*, namely, the intellectual habit of practical principles. Experience is also necessary because every moral action is the result of a deliberation and the choice of a specific good called a *deliberate desire* or *proairesis*. There, intelligence and affectivity share its deepest roots and reference to the human heart gains meaning. *Habits of the heart* is used here as a technical term that should be understood as the exercise and perfection of the ties that unify objective and subjective approaches to knowledge.

We must avoid misinterpreting the claim that concrete experience is fundamental to prudence. It does not mean that prudence is confined to experiences. The agent, and the world as a whole, are assumed and expressed in each deliberate desire, in each exercise of the heart. This inclusion is analogous to a spider web in that the behavior of one of its nodes depends on and reflects the entire system, which is characteristic of the response in systems that have network properties. Considering the background of actions in this way connects the need for experience with the need for science since this deliberate desire also takes into account that which is necessary and objective regarding human persons and their world.

One of Aristotle's best-known claims summarizes the role of active experience in ethical learning. "For the thing

we have to learn before we can do them, we learn by doing them, e.g. men become builders by building and lyre-players by playing the lyre; so too we become just by doing just acts, temperate by doing temperate acts, brave by doing brave acts" (Ibid., Book II, Chapter 1, 1103b, pp. 28-29). To some extent, this approach supports classical medical ethics' protectionist theses. A doctor's opinion on his patient's good somehow takes priority over the opinions of those who analyze that good from a purely objective point of view. However, this is only true if said opinion is based on virtues that transcend the strict search for health. It is here where Aristotle's view gives weight to bioethics' opening-up theses – they elevate medicine to a political task and, for Aristotle, politics is the science of the ultimate and best good. "The end of this science must include those of the others, so that this end must be the good for man" (Ibid., Book I, Chapter 2, 1094b 1-5, p. 2). In this way, a good doctor seeks to practice politics in his art, and he does so insofar as he tries to restore health to patients, knowing that they also aspire to happiness. A good doctor is, therefore, a good citizen who dedicates part of her time to reflection, dialogue and exercise of political activity. More than in any other, prudence reigns as the fundamental virtue in this task.

In translating this discourse to the present proposal, we can see that if bioethics does not assist medical ethics in the work of reconciling health, happiness and the universal good and if we reduce medical ethics to an ethic devised by doctors alone (sometimes also called clinical ethics), then medical ethics not only does not help, but also actively hinders professional activity. This error is as disastrous as reducing medical ethics to a pure argumentative game, that is,to a bioethics blind to medical experience. These are two sides of the same error-laden coin and produce similar results, namely a profession at the mercy of power struggles or of patients' caprice.

The habits of the heart

This relationship between art, science and politics inverts Stern's vocational training pyramid. In the first place, professionalism should be placed at the base of the pyramid to provide medical students and young doctors with all the experiences and first reflections that are necessary for understanding the subsequent step in medical ethics and, finally, in bioethics. The reason behind this is move follows Aristotle: "Hence any one who is to listen intelligently to lectures about what is noble and just and, generally, about the subjects of political science must have been brought up in good habits" (Ibid, Book I, Chapter IV, 1095b 5-10, p. 5). As he argues, no treatise on ethics, no matter how accurate and profound can move anyone towards the good. Real knowledge, that which reaches the operational level, must be accompanied by the subjective, experiential dimension in a process called *understanding*. Indeed, deliberation without desire is one of the great evils of contemporary bioethics, whose discourse is often inadequately connected with medical experience and, therefore, lacks persuasive power among professionals who are increasingly skeptical of bioethics in particular or, what is worse, of ethics in general.

Ethical reflection requires habits, i.e., certain behavioral, intellectual and affective predispositions that arise from practice and learning. Increased sensitivity is one of the most important effects of habit. A doctor's first visits to a patient and first considerations of what might be good for her are a great opportunity for apprehending ethical principles and also many simple, but fundamental ideals, all of which strengthen the doctor's maturity. However, any type of experience and reflection whatsoever is insufficient for such growth. Every sommelier knows that students must follow the appropriate steps to become wine tasting experts. Knowledge and a taste for wine, which is always sour at first, require patience and good lessons. Today, there are even neuroscientific studies that support this thesis (Plassmann et al., 2008). Ideas are capable of changing our affective relationship with the environment and, most importantly, our very perception of reality. This search for perfection can be called *sensory contemplation*, which is the first step in developing the habits of the heart; in it, the intellect participates like a radio dial.

Teacher play a leading role in this first stage of *professionally* teaching medicine and serve as a reference for students to observe, imitate and listen to. In addition, artistic works are useful in this initial training step in that they teach doctors to look at reality through the eyes of an artist. The latter is usually better trained to identify marvels in the most mundane of moments or even, like in Fyodor Dostoevsky's novels, in the horror of confinement, disease, and suffering.

In the next stage, as doctors grow in the first virtues, discursive activity becomes more relevant in that ideals arise, nuances are no longer trivial, inferences become more complex, etc. In short, improving methods and dialogue becomes imperative for professional growth. At this intermediate point, tradition plays an important role as a reservoir of paths that have been walked down before. It is an essential basis for correctly interpreting contemporary medical thinking and feeling. Recalling this ancient reservoir guards against one of the evils that haunts both classical and autonomist professionalism, namely their break with a tradition rashly seen as solipsistic and outdated. This rupture did not come about based on examining the reasons that led old ways of thinking to their decline, for example, analyzing the Cartesian turn mentioned previously. This sort of mistake frequently leads to amendments to the whole and, with it, to the rejection of the good that tradition potentially contains.

Contemporary professionalism designs many of its projects with its back to more than two millennia of thought, thus running the risk of repeating the same mistakes. This degenerative process does not just affect medicine. As the

Spanish philosopher José Ortega y Gasset correctly diagnosed in the 1920s, this phenomenon is due to a widespread belief that the understanding of history – what he calls *historical reason* – is wholly separate from the sustainability of achievements in the present. "Civilization is not 'just there,' it is not self-supporting. It is artificial and requires the artist or the artisan. If you want to make use of the advantages of civilization, but are not prepared to concern yourself with the upholding of civilization – you are done. In a trice you find yourself left without civilization. Just a slip, and when you look around everything has vanished into air. The primitive forest appears in its native state, just as if curtains covering pure Nature had been drawn back. The jungle is always primitive and, vice versa, everything primitive is mere jungle" (Ortega y Gasset, 1951, p. 97). Buildings and social practices (as monuments and ancient traditions) last longer than other, more important things in civilization, namely moral or prudential sensitivity, i.e., that which members of a community understand (*see*) as the meaning of their practices, the pursued good and the proper means for reaching it. If contemporary medical students have difficulty grasping what was evident to their predecessors, it is probably because their teachers, often with irreproachable conduct and attitudes, transmit fewer arguments, or weaker arguments, for explaining their decisions and habits.

This new *presentist* professionalism also leads to decline in the imitation of behavior. In other words, circumscribing the field of medical knowledge to the here and now changes doctors of the future in significant and disastrous ways, especially with respect to the patient. One of the great conquests of the civilizing spirit was precisely the conquest of our current sensitivity towards patients. If history is forgotten – invisible as it is to our eyes – said virtue will end up confined in a museum display case like the mummies of Egypt, no matter how sensitive and well-intentioned today's medical educators may be. Sensitivity can be, in this context, a double-edged sword because, as Aristotle writes, "[f]or the fact is a starting-point, and if this is sufficiently plain to him, he will not need the reason as well" (Aristotle, Nicomachean Ethics, Book I, Chapter IV, 1095b 5-10, pp. 5-6). Indeed, seeing things is in itself good – the best in the moral sphere. However, it is also disastrous if it is accompanied by a wrong idea, in this case, the belief that one can dismiss the shoulders of the giants upon which we figuratively stand.

Alasdair MacIntyre, another contemporary philosopher who has exhaustively studied the effects of historical blindness on individual and social virtues, also writes about the natural mirage that affects modern education in moral sensitivity. Specifically, in his most famous book, *After Virtue*, he denounces our forgetfulness of one of the great advances in the classical world, namely understanding human action as deliberate desire that, as noted earlier, demands we pay attention to the part and the whole. This forgetfulness has resulted in the involution of Western thought towards obsession with the study of parts. Post-Cartesian methodological bias is a primary example of the evil that is now spreading even outside of the sciences. "The social obstacles derive from the way in which modernity partitions each human life into a variety of segments, each with its own norms and modes of behavior. So work is divided from leisure, private life from public, the corporate from the personal. So both childhood and old age have been wrenched away from the rest of human life and made over into distinct realms. And all these separations have been achieved so that it is the distinctiveness of each and not the unity of the life of the individual who passes through these parts in terms of which we are taught to think and to feel" (MacIntyre, 1984, 204). Recovering thinking and feeling – i.e., the Western heart – requires looking to the past and, from there, to the whole of which we are part. The latter movement constitutes the leap that medical ethics must take towards bioethics to safeguard professionals from the bad winds of change and to help them take advantage of the good ones in order to reach new and better destinations.

Towards citizenship

A doctor's training begins with observation of reality, continues with studying the past and concludes with dialogue among those who can help him imbue his actions with as much political meaning as possible, which, as mentioned, consists in knowing how to relate health, happiness and the universal good. The thin line that separates these three terms also serves, as Aviva Preminger et al. argue, to differentiate professionalism from ethics: "For example, a surgeon who posts patient images without consent is unethical. However, the surgeon who posts lewd patient images with consent is unprofessional. It is often unclear where ethics ends and professionalism begins and the two are therefore often conflated" (2018). If we follow this argument, we could invert the terms that Preminger et al. use as follows: the former example would pertain to professionalism and the latter to bioethics. What matters here is that the former example points to a question that is easily evaluated using the internal logic of medicine, while the latter is not directly related to health and, therefore, cannot be easily assessed in this single light. Diagnostic images are a medical means used here for the wholly unrelated end of pornographic consumption. The problem is not, in itself, changing the end, which can be legitimate and appropriate (for example, the use of medical knowledge to improve athletes' performance), but rather is found in the suitability of the new ends and their use in the pursuit of happiness.

What is the greatest good to which a human being can aspire and what actions can help him achieve it? The former is one of the great philosophical questions and corresponds to Pythagoras' overall understanding of philosophy. Even more important, according to the Neoplatonist philosopher

Iamblichus, Pythagoras defined the philosopher as one who is dedicated to the study of the most beautiful things, an idea that Aristotle also shares. Wonder is hidden deep in things: "All begin, as we have said, by wondering that things should be as they are, e.g., with regard to marionettes, or the solstices, or the incommensurability of the diagonal of a square; because it seems wonderful to everyone who has not yet perceived the cause that a thing should not be measurable by the smallest unit. But we must end with the contrary and (according to the proverb) the better view, as men do even in these cases when they understand them" (Aristotle, Metaphysics, Book I, A, 980a-993a). Awe arises with increased understanding of the particular *physis* of a natural object, but reaches its peak with understanding of the universal *physis*, which is the philosopher's highest reward and, above all, the key to happiness for a rational being such as man. Indeed, happy is the man who knows where to go, who knows where everything is going.

In the political sense conferred here, bioethics requires a certain maturity. "A Young man is not a proper hearer of lectures on political science; for he is inexperienced in the actions that occur in life, but is discussions start from these and are about these" (Aristotle, *Nicomachean Ethics,* Book I, Chapter III, 1095A 1-10, p. 3). While a young doctor is trained in the intellectual and moral virtues necessary for *sensory contemplation* in his daily practice, a mature doctor acquires the virtue of *intellectual contemplation* in the *agora*. Said contemplation, in line with Platonism, is the last instance of the habits of the heart; herein, the intellect is capable of apprehending and enjoying ultimate causes and the highest ideals in a quasi-intuitive way. At this stage, the main catalyst pertains to a proper dialectic, i.e., good dialogue, rather than to experience (Llano, 2007).

At this point, it is important to mention interdisciplinary training from the perspective of access to the good as a sort of prudential training, rather than from the perspective of the more common approach of access to the truth. In the case of medicine, this last formative stage is equivalent to training in bioethics, thus assigning to bioethics much more extensive functions than those conferred to it to date. This is so because doctors' true reward is found in the global kind of interdisciplinarity that compares the totality that each human action demands, rather than a local look. Thus, the most effective bioethics is supported by university faculties.

The obstacles in going from medical ethics to bioethics are not small. The first of them is linked to ignoring or undervaluing artistic studies in academia. Interdisciplinarity as outlined here requires openness to the world, which is only feasible if it brings together different types of knowledge, including experiences and feelings. Very seldom are artists invited to participate in interdisciplinary medical training programs.

A second obstacle involves widespread university-level disinterest (and growing inability) in maintaining worldviews or generating new ones, which is in large part due to, as mentioned, the triumph of atomizing post-Cartesian schemes in the highest intellectual spheres of society. Ortega y Gasset laments that the West has forgotten the goal that was once one of its great civilizing achievements. "Is the higher education nothing more than professionalism and research? … The medieval university does not research. It is very little concerned with professions. All is 'general culture' – theology, philosophy, 'arts.' But what is called 'general culture' today was something very different for the Middle Ages. It was not an ornament for the mind or a training of the character. It was, on the contrary, the system of ideas, concerning the world, and humanity, which the man of that time possessed. It was, consequently, the repertory of convictions which became the effective guide of existence" (Ortega y Gasset, 1983, pp. 36-37).

Medieval university was directed toward the formation of prudent men, that is, people who study happiness to find how to do the good in each concrete situation. They are what we would call intellectuals today, the vanguard of true civilizational progress – people who pursue and are lured by goods that consolidate and move a true community rather than being obsessed with the development of technology. "Life is chaos, a tangle and confused jungle in which man is lost. But his mind reacts against the sensation of bewilderment: he labors to find 'roads,' 'ways' through the woods, in the form of clear, firm ideas concerning the universe, positive convictions about the nature of things. The ensemble, or system, of these ideas is culture in the true sense of the term: it is precisely the opposite of external ornament. Culture is what save human life from being a mere disaster; it is what enables man to live a life which is something about meaningless tragedy or inward disgrace" (Idem). Of course, this Spanish philosopher understands that the university's political mission inevitably identifies with its most philosophical mission since the search for truth, which is always a search for beauty, also requires all researchers' collaboration, and ends up connecting all things. Paradoxically, the contemporary university, based on ignorance, scruples or mistrust, seems to defend the study of truth, but suppresses its responsibility toward the study of happiness.

Universities are reducing their political-scientific aims to mere technical training. Today, *profession* means training students to meet each society's particular demands at all times for reasons we have already explored. The situation is grave and has reached a point in which even students' expectations have become a central evaluation criterion in rating the quality of teaching. This contradicts institutions' true purpose, which corresponds to transforming and elevating students' expectations and ideals. This trend holds true for medicine as well. The humanist doctor, who was once a regular in cultural and political forums, has been replaced by hyperspecialists who, according to Ortega y Gasset, constitute a new type of barbarian or worse for having turned intellec-

tual vulgarity into a duty. The hyper-specialist researcher, he writes, "is only acquainted with one science, and even of that one only knows the small corner in which he is an active investigator. He even proclaims it as a virtue that he takes no cognizance of what lies outside the narrow territory specially cultivated by himself, and gives the name of 'dilettantism' to any curiosity for the general scheme of knowledge" (Ortega y Gasset, 1951, p. 122).

Ironically, more and more hyper-specialists seem to support supposedly interdisciplinary initiatives. Some of them do so because they want to open up lines of research that have to date only produced failed hypotheses – a legitimate intention, but one that fails to recognize the important goals of interdisciplinary dialogue. Others try to preserve something of the university tradition based only on a nostalgic and capricious attachment to its ancient instantiation. Others cling to the feeling of power associated with the label of "intellectual." In close step, some just want to make money in other fields when the notoriety expected in their field of origin fails to deliver. Finally, others wish to produce intellectuals for purposes beyond profit, although without renouncing the concept of hyper-specialism. Obviously, all of these attempts will fail because knowing a lot about something is not enough for understanding the other, much less the entire world – no matter whether the hyper-specialists is an expert in science, art or a modern version of philosophy.

Returning to the origins of philosophy based in the Socratic tradition, the main ingredient in interdisciplinary formation is awe for the object of study, which is authentic when it spreads to those who collaborate in its pursuit. Only dialogue with awe, which is also dialogue with charity, enables intellectual contemplation. Conversely, persisting in dialogue is only possible starting from intellectual contemplation (Echarte, 2016), but – a word to the wise – this loving attitude can also be imposed on the other and even on oneself, which constitutes the worst kind of self-deception. Some interdisciplinary schools and projects justify its members' greed in the name of the love of science, society or even in the name of God. Religious believers must be especially vigilant against this third case because, when a working environment falls into this kind of error (a sort of institutional sin against its Spirit), it is very difficult to avoid the production of labyrinthine persuasive and self-indulgent pseudo-knowledge. And it eventually leads to a massive loss of sensitivity towards the truth, the good, and the person. However, successful it may be in the world's eyes, it is best to abandon a given research or training project that falls into this *abomination of desolation*, using a biblical expression, because even its best members could not avoid being infected with this voluntary but progressively unconscious deafness. Words there are useless. The only way to prevent the spread of this scandalous vice is bearing witness by abandoning the project. Faith, compassion and a great sense of humour are the most effective weapons in this last flight.

Conclusions

A good university is especially talented at fomenting dialogue because it trains its community (students and professors) in two of the most philosophical virtues, namely love and humility. I will conclude this paper by discussing the role of the latter in bioethics training.

Dialogue requires acceptance of the fact that, no matter how long one has studied, one can be wrong. This attitude results in a growing ability to listen to the other and the audacity to enter lands that bring the consolidated professional back to the position of student. The primary obstacle to this challenge is pride, which, as Sellés argues based on texts by Thomas Aquinas, is counted among the main vices in the university setting (2008). The second obstacle is the arrogance that is often attributed to doctors, which must be well understood to counteract it. This arrogance does not usually involve internal attitudes, but rather the inevitable divinizing gaze of patients who daily entrust doctors with their vulnerability and confidence. Without proper precautions in the patient-physician relationship, over time it is increasingly difficult to reject such a false image. This temptation is even stronger for those who treat the soul, as well as for philosophers who, by tradition, place this virtue at the heart of their profession. Part of the blame lies with the false belief that humility and wisdom require nothing more than a college degree. This tends to be forgotten due to professionals' natural tendency to try to maintain the most characteristic image of their profession. However, not listening and not learning is better than pretending to be listening and learning.

Here we find the two main obstacles in doctor's interdisciplinary (bioethical) training, which hinder, on the one hand, prudential training of doctors and, on the other hand, their contribution to contemporary worldviews. The two main theses described herein are also remedies against them. In short, the first recommends returning to the heart of medicine that is, to rehabilitating its subjective dimension and learning to properly embed it in physicians' knowledge and practice. In other words, it involves giving back professionals their capacity for awe, i.e., for understanding their art. There is no greater guide for avoiding missteps, and no more favorable wind for avoiding professional drift towards partisan interests.

The second thesis involves achieving this goal with three consecutive training stages. The first must be practical because the first habit of the heart, the virtue of sensory contemplation, is only possible in clinical experience. Those dedicated to professionalism are ideal candidates for leading these first steps. In an intermediate stage, doctors are taught to avoid naive approaches by studying ethics from the internal logic of medicine, a task assigned to scholars of the history of professional thought. Here, medical ethics is involved. This professional training then culminates in the acquisition of the second habit of the heart, *intellectual contemplation*,

with which doctors are able to decide what is truly best for each patient, to assume responsibilities as citizens and, last but not least, to make medicine their passion (Echarte, Grijalba, 2017). Bioethicists would be the best choice for introducing professionals to this third phase of training, which is typically university-based.

The first part of this article described an intellectual climate that is not entirely conducive to implementing such a training project. Are there reasons for hope or is Western culture facing its decline? The answer depends, first of all, on a few citizens, on individuals who, as Ortega y Gasset describes them, are aware that they need "neither protection, attention nor sympathy from the masses. [They] maintain [their] character of complete inutility, and thereby free [themselves] from all subservience to the average man… and joyously accept [their] free destiny as bird[s] of the air [a bird of the Good God, in the Spanish original text], without asking anybody to take [them] into account, without recommending or defending [themselves]" (Ortega y Gasset 1951, p. 93). The work and sacrifice of a few would be more than enough to chase away the current shadows that threaten everything, including medical sensitivity.

Second, the new generation's power should not be underestimated. Young people start from scratch and, therefore, are still capable of capturing the ideals that emanate from reality, even if they are found at the most sensitive (lowest) level. For that very reason, today more than ever, teachers must pay attention and learn in their classrooms.

I finish with a reflection on a certain advantage that the medical profession has in terms of avoiding intellectual vulgarity in comparison with fields dedicated to pure speculation. The beliefs of those who practice the former, however firm they may be, are subjected to unrelenting reality every day. Suffering and death are extraordinary reminders of human fallibility and the transformative power of compassion. It is more difficult for physicians (a word whose Greek root is *physis*) to become empty fortresses full of blatantly false ideas. Indeed, humanist doctors are nothing other than well-trained doctors who have learned to overcome despotic and faint-hearted attitudes. They constitute excellent both gray and green travel companions in the journey of knowledge and life.

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