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<CT>Moral Character</CT>

Chapter 1 concentrated on moral norms in the form of principles, rules, obligations, and rights. This chapter focuses on moral character, especially moral virtues, moral ideals, and moral excellence. These categories complement those in the previous chapter. The moral norms discussed in Chapter 1 chiefly govern right and wrong *action*. By contrast, character ethics and virtue ethics concentrate on the *agent* who performs actions and the virtues that make agents morally worthy persons.[1]

The goals and structure of medicine, health care, public health, and research call for a deep appreciation of moral virtues. What often matters most in healthcare interactions and in the moral life generally is not adherence to moral rules, but having a reliable character, good moral sense, and appropriate emotional responsiveness. Even carefully specified principles and rules do not convey what occurs when parents lovingly play with and nurture their children or when physicians and nurses exhibit compassion, patience, and responsiveness in their encounters with patients and families. The feelings and concerns for others that motivate us to take actions often cannot be reduced to a sense of obligation to

follow rules. Morality would be a cold and uninspiring practice without appropriate sympathy, emotional responsiveness, excellence of character, and heartfelt ideals that reach beyond principles and rules.

Some philosophers have questioned the place of virtues in moral theory. They see virtues as less central than action-guiding norms and as difficult to unify in a systematic theory, in part because there are many independent virtues to be considered. Utilitarian Jeremy Bentham famously complained that there is "no marshaling" the virtues and vices because "they are susceptible of no arrangement; they are a disorderly body, whose members are frequently in hostility with one another. . . . Most of them are characterized by that vagueness which is a convenient instrument for the poetical, but dangerous or useless to the practical moralist."[2]

Although principles and virtues are different and learned in different ways, virtues are no less important in the moral life, and in some contexts are probably more important. In Chapter 9, we examine virtue ethics as a type of moral theory and address challenges and criticisms such as Bentham's. In the first few sections of the present chapter, we analyze the concept of virtue; examine virtues in professional roles; treat

the moral virtues of care, caregiving, and caring in health care; and explicate five other focal virtues in both healthcare and research.

<1>The Concept of Moral Virtue</1>

A *virtue* is a dispositional trait of character that is socially valuable and reliably present in a person, and a *moral virtue* is a dispositional trait of character that is morally valuable and reliably present. If cultures or social groups approve a trait and regard it as moral, their approval is not sufficient to qualify the trait as a moral virtue. Moral virtue is more than a personal, dispositional trait that is socially approved in a particular group or culture.[3] This approach to the moral virtues accords with our conclusion in Chapter 1 that the common morality excludes provisions found in so-called cultural moralities and individual moralities. The moral virtues, like moral principles, are part of the common morality.

Some define the term *moral virtue* as a disposition to act or a habit of acting in accordance with, and with the aim of following, moral principles, obligations, or ideals.[4] For example, they understand the moral virtue of nonmalevolence as the trait of abstaining from causing harm to others when it would be wrong to cause harm. However, this definition unjustifiably views

virtues as merely derivative from and dependent on principles and fails to capture the importance of moral motives. We care morally about people's motives, and we care especially about their characteristic motives and dispositions, that is, the motivational structures embedded in their character. Persons who are motivated through impartial sympathy and personal affection, for example, are likely to meet our moral approval, whereas persons who act similarly, but are motivated merely by personal ambition, do not.

Consider a person who discharges moral obligations only because they are moral requirements, while intensely disliking being obligated to place the interests of others above his or her personal interests and projects. This person does not feel friendly toward or cherish others and respects their wishes only because moral obligation requires it. If this person's motive is improper, a critical moral ingredient is missing even though he or she consistently performs morally right actions and has a disposition to perform right actions. When a person characteristically lacks an appropriate motivational structure, a necessary condition of virtuous character is absent. The act may be right and the actor blameless, but neither the act nor the actor is *virtuous.* People may be disposed to do what

is right, intend to do it, and do it, while simultaneously yearning to avoid doing it. Persons who characteristically perform morally right actions from such a motivational structure are not morally virtuous even if they invariably perform the morally right action.

Such a person has a morally deficient character, and he or she performs morally right actions for reasons or feelings disconnected from moral motivation. A philanthropist's gift of a new wing of a hospital will be recognized by hospital officials and by the general public as a generous gift, but if the philanthropist is motivated only by a felt need for public praise and only makes the gift to gain such praise, there is a discordance between those feelings and the performance of the praised action. Feelings, intentions, and motives are morally important in a virtue theory in a way that may be lost or obscured in an obligation-based theory.[5]

<1>Virtues in Professional Roles</1>

Persons differ in their sets of character traits. Most individuals have some virtues and some vices while lacking other virtues and vices. However, all persons with normal moral capacities can cultivate the character traits centrally important to morality such as honesty, fairness, fidelity, truthfulness, and benevolence. In professional life in healthcare and research the traits that warrant encouragement

and admiration often derive from role responsibilities. Some virtues are essential for enacting these professional roles, and certain vices are intolerable in professional life. Accordingly, we turn now to virtues that are critically important in professional and institutional roles and practices in biomedical fields.

<2>**Virtues in Roles and Practices**</2>

Professional roles are grounded in institutional expectations and governed by established standards of professional practice. Roles internalize conventions, customs, and procedures of teaching, nursing, doctoring, and the like. Professional practice has traditions that require professionals to cultivate certain virtues. Standards of virtue incorporate criteria of professional merit, and possession of these virtues disposes persons to act in accordance with the objectives of the practices.

In the practice of medicine several goods internal to the profession are appropriately associated with being a good physician. These goods include specific moral and nonmoral skills in the care of patients, the application of specific forms of knowledge, and the teaching of health behaviors. They are achievable only if one lives up to the standards of the good physician, standards that in part define the practice. A practice is not merely a set of technical skills.

Practices should be understood in terms of the respect that practitioners have for the goods internal to the practices. Although these practices sometimes need to be revised, the historical development of a body of standards has established many practices now found at the heart of medicine, nursing, and public health.[6]

Roles, practices, and virtues in medicine, nursing, and other health care and research professions reflect social expectations as well as standards and ideals internal to these professions.[7] The virtues we highlight in this chapter are care—a fundamental virtue for health care relationships—along with five focal virtues found in all health-care professions: compassion, discernment, trustworthiness, integrity, and conscientiousness, all of which support and promote caring and caregiving. Elsewhere in this chapter and in later chapters, we discuss other virtues, including respectfulness, nonmalevolence, benevolence, justice, truthfulness, and fidelity.

To illustrate the difference between standards of moral character in a profession and standards of technical performance in a profession, we begin with an instructive study of surgical error. Charles L. Bosk's influential *Forgive and Remember: Managing Medical Failure* presents an ethnographic study of the way two surgical services handle medical failure, especially failures by surgical residents in "Pacific Hospital" (a name substituted for the hospitals actually

studied).[8] Bosk found that both surgical services distinguish, at least implicitly, between several different forms of error or mistake. The first form is *technical*: A professional discharges role responsibilities conscientiously, but his or her technical training or information still falls short of what the task requires. Every surgeon will occasionally make this sort of mistake. A second form of error is *judgmental*: A conscientious professional develops and follows an incorrect strategy. These errors are also to be expected. Attending surgeons forgive momentary technical and judgmental errors but remember them when a pattern develops indicating that a surgical resident lacks the technical and judgmental skills to be a competent surgeon. A third form of error is *normative:* A physician violates a norm of conduct or fails to possess a moral skill, particularly by failing to discharge moral obligations conscientiously or by failing to acquire and exercise critical moral virtues such as conscientiousness. Bosk concludes that surgeons regard technical and judgmental errors as less important than moral errors, because every conscientious person can be expected to make "honest errors" or "good faith errors," whereas moral errors such as failures of conscientiousness are considered profoundly serious when a pattern indicates a defect of character.

Bosk's study indicates that persons of high moral character acquire a reservoir of goodwill in assessments of either the praiseworthiness or the blameworthiness of their actions. If a conscientious surgeon and another surgeon who is not adequately conscientious make the same technical or judgmental errors, the conscientious surgeon will not be subjected to moral blame to the same degree as the other surgeon.

<2>**Virtues in Different Professional Models**</2>

Professional virtues were historically integrated with professional obligations and ideals in codes of health care ethics. Insisting that the medical profession's "prime objective" is to render service to humanity, an American Medical Association (AMA) code in effect from 1957 to 1980 urged the physician to be "upright" and "pure in character and . . . diligent and conscientious in caring for the sick." It endorsed the virtues that Hippocrates commended: modesty, sobriety, patience, promptness, and piety. However, in contrast to its first code of 1847, the AMA over the years has increasingly de-emphasized virtues in its codes. The 1980 version for the first time eliminated all trace of the virtues except for the admonition to expose "those physicians deficient in character or competence." This pattern of de-emphasis regrettably still continues.

Thomas Percival's 1803 book, *Medical Ethics,* is a classic example of an attempt to establish the proper set of virtues in medicine. Starting from the assumption that the patient's best medical interest is the proper goal of medicine, Percival reached conclusions about the good physician's traits of character, which were primarily tied to responsibility for the patient's medical welfare.[9] This model of medical ethics supported medical paternalism with effectively no attention paid to respect for patients' autonomous choices.

In traditional nursing, where the nurse was often viewed as the "handmaiden" of the physician, the nurse was counseled to cultivate the passive virtues of obedience and submission. In contemporary models in nursing, by contrast, active virtues have become more prominent. For example, the nurse's role is now often regarded as one of advocacy for patients.[10] Prominent virtues include respectfulness, considerateness, justice, persistence, and courage.[11] Attention to patients' rights and preservation of the nurse's integrity also have become increasingly prominent in some contemporary models.

The conditions under which ordinarily praiseworthy virtues become morally unworthy present thorny ethical issues. Virtues such as loyalty, courage, generosity, kindness, respectfulness, and benevolence at times lead persons to act inappropriately and unacceptably. For instance, the physician who acts kindly and

loyally by not reporting the incompetence of a fellow physician acts unethically. This failure to report misconduct does not suggest that loyalty and kindness are not virtues. It indicates only that the virtues need to be accompanied by an understanding of what is right and good and of what deserves loyalty, kindness, generosity, and the like.

<1>The Central Virtue of Caring</1>

As the language of *health care, medical care,* and *nursing care* suggests, the virtue of care, or caring, is prominent in professional ethics. We treat this virtue as fundamental in relationships, practices, and actions in health care. In explicating this family of virtues we draw on what has been called the *ethics of care,* which we interpret as a form of virtue ethics.[12] The ethics of care emphasizes traits valued in intimate personal relationships such as sympathy, compassion, fidelity, and love. *Caring* refers to care for, emotional commitment to, and willingness to act on behalf of persons with whom one has a significant relationship. *Caring for* is expressed in actions of "caregiving," "taking care of," and "due care." The nurse's or physician's trustworthiness and quality of care and sensitivity in the face of patients' problems, needs, and vulnerabilities are integral to their professional moral lives.

The ethics of care emphasizes what physicians and nurses do—for example, whether they break or maintain confidentiality—and how they perform those actions, which motives and feelings underlie them, and whether their actions promote or thwart positive relationships.

<2>**The Origins of the Ethics of Care**</2>

The ethics of care, understood as a form of philosophical ethics, originated and continues to flourish in feminist writings. The earliest works emphasized how women display an ethic of care, by contrast to men, who predominantly exhibit an ethic of rights and obligations. Psychologist Carol Gilligan advanced the influential hypothesis that "women speak in a different voice"—a voice that traditional ethical theory failed to appreciate. She discovered "the voice of care" through empirical research involving interviews with girls and women. This voice, she maintained, stresses empathic association with others, not based on "the primacy and universality of individual rights, but rather on . . . a very strong sense of being responsible."[13]

Gilligan identified two modes of moral thinking: an ethic of care and an ethic of rights and justice. She did not claim that these two modes of thinking strictly correlate with gender or that all women or all men speak in the same moral

voice.[14] She maintained only that men tend to embrace an ethic of rights and justice that uses quasi-legal terminology and impartial principles, accompanied by dispassionate balancing and conflict resolution, whereas women tend to affirm an ethic of care that centers on responsiveness in an interconnected network of needs, care, and prevention of harm.[15]

<2>**Criticisms of Traditional Theories by Proponents of an Ethics of Care**</2>

Proponents of the care perspective often criticize traditional ethical theories that tend to de-emphasize virtues of caring. Two criticisms merit consideration here.[16]

<3>***Challenging impartiality.***</3> Some proponents of the care perspective argue that theories of obligation unduly telescope morality by overemphasizing detached fairness. This orientation is suitable for some moral relationships, especially those in which persons interact as equals in a public context of impersonal justice and institutional constraints, but moral detachment also may reflect a lack of caring responsiveness. In the extreme case, detachment becomes uncaring indifference. Lost in the *detachment* of impartiality is an *attachment* to what we care about most and is closest to us—for example, our loyalty to family,

friends, and groups. Here partiality toward others is morally permissible and is an expected form of interaction. This kind of partiality is a feature of the human condition without which we might impair or sever our most important relationships.[17]

Proponents of a care ethics do not recommend complete abandonment of principles if principles are understood to allow room for discretionary and contextual judgment. However, some defenders of the ethics of care find principles largely irrelevant, ineffectual, or unduly constrictive in the moral life. A defender of principles could hold that principles of care, compassion, and kindness tutor our responses in caring, compassionate, and kind ways. But this attempt to rescue principles seems rather empty. Moral experience confirms that we often do rely on our emotions, capacity for sympathy, sense of friendship, and sensitivity to find appropriate moral responses. We could produce rough generalizations about how caring clinicians should respond to patients, but such generalizations cannot provide adequate guidance for all interactions. Each situation calls for responses beyond following rules, and actions that are caring in one context may be offensive or even harmful in another.

<3>***Relationships and emotion.***</3> The ethics of care places special emphasis

on mutual interdependence and emotional responsiveness. Many human relationships in health care and research involve persons who are vulnerable, dependent, ill, and frail. Feeling for and being immersed in the other person are vital aspects of a moral relationship with them.[18] A person seems morally deficient if he or she acts according to norms of obligation without appropriately aligned feelings, such as concern and sympathy for a patient who is suffering. Good health care often involves insight into the needs of patients and considerate attentiveness to their circumstances.[19]

In the history of human experimentation, those who first recognized that some subjects of research were brutalized, subjected to misery, or placed at unjustifiable risk were persons able to feel sympathy, compassion, disgust, and outrage about the situation of these research subjects. They exhibited perception of and sensitivity to the feelings of subjects where others lacked comparable perceptions, sensitivities, and responses. This emotional sensitivity does not reduce moral response to emotional response. Caring has a cognitive dimension and requires a range of moral skills that involve insight into and understanding of another's circumstances, needs, and feelings.

One proponent of the ethics of care argues that action is sometimes appropriately principle-guided, but not necessarily always governed by or derived

from principles.[20] This statement moves in the right direction for construction of a comprehensive moral framework. We need not reject principles of obligation in favor of virtues of caring, but moral judgment clearly involves moral skills beyond those of specifying and balancing general principles. An ethic that emphasizes the virtues of caring can serve health care well because it is close to the relationships and processes of decision making found in clinical contexts, and provides insights into basic commitments of caring and caretaking. It also liberates health professionals from the narrow conceptions of role responsibilities that have been delineated in some professional codes of ethics.

<1>Five Focal Virtues</1>

We now turn to five focal virtues for health professionals: compassion, discernment, trustworthiness, integrity, and conscientiousness. These virtues are important for the development and expression of caring, which we have presented as a fundamental orienting virtue in health care. These five additional virtues provide a moral compass of character for health professionals that builds on centuries of thought about health care ethics.[21]

<2>**Compassion**</2>

Compassion, says Edmund Pellegrino, is a "prelude to caring."[22] The virtue of compassion combines an attitude of active regard for another's welfare together with sympathy, tenderness, and discomfort at another's misfortune or suffering.[23] Compassion presupposes sympathy, has affinities with mercy, and is expressed in acts of beneficence that attempt to alleviate the misfortune or suffering of another person.

Nurses and physicians must understand the feelings and experiences of patients to respond appropriately to them and their illnesses and injuries—hence the importance of empathy, which involves sensing or even reconstructing another person's mental experience, whether that experience is negative or positive.[24] As important as empathy is for compassion and other virtues, the two are different and empathy does not always lead to compassion. Some literature on professionalism in medicine and health care now often focuses on empathy rather than compassion, but this literature risks making the mistake of viewing empathy alone as sufficient for humanizing medicine and health care while overlooking its potential dangers.[25]

Compassion generally focuses on others' pain, suffering, disability, or misery—the typical occasions for compassionate response in health care. Using the language of *sympathy,* eighteenth-century philosopher David Hume pointed to

a typical circumstance of compassion in surgery and explained how such feelings arise:

> <EXT>Were I present at any of the more terrible operations of surgery, 'tis certain, that even before it begun, the preparation of the instruments, the laying of the bandages in order, the heating of the irons, with all the signs of anxiety and concern in the patient and assistants, wou'd have a great effect upon my mind, and excite the strongest sentiments of pity and terror. No passion of another discovers itself immediately to the mind. We are only sensible of its causes or effects. From *these* we infer the passion: And consequently *these* give rise to our sympathy.[26]</EXT>

Physicians and nurses who express little or no compassion in their behavior may fail to provide what patients need most. The physician, nurse, or social worker altogether lacking in the appropriate display of compassion has a moral weakness. However, compassion also can cloud judgment and preclude rational and effective responses. In one reported case, a long-alienated son wanted to continue a futile and painful treatment for his near-comatose father in an intensive care unit (ICU) to have time to "make his peace" with his father. Although the son understood that his alienated father had no cognitive capacity, the son wanted to work through his sense of regret and say a proper good-bye. Some hospital staff

argued that the patient's grim prognosis and pain, combined with the needs of others waiting to receive care in the ICU, justified stopping the treatment, as had been requested by the patient's close cousin and informal guardian. Another group in the unit regarded continued treatment as an appropriate act of compassion toward the son, who they thought should have time to express his farewells and regrets to make himself feel better about his father's death. The first group, by contrast, viewed this expression of compassion as misplaced because of the patient's prolonged agony and dying. In effect, those in the first group believed that the second group's compassion prevented clear thinking about primary obligations to this patient.[27]

Numerous writers in the history of ethical theory have proposed a cautious approach to compassion. They argue that a passionate, or even a compassionate, engagement with others can blind reason and prevent impartial reflection. Health care professionals understand and appreciate this phenomenon. Constant contact with suffering can overwhelm and even paralyze a compassionate physician or nurse. Impartial judgment sometimes gives way to impassioned decisions, and emotional burnout can arise. To counteract this problem, medical education and nursing education are well designed when they inculcate detachment alongside

compassion. The language of *detached concern* and *compassionate detachment* came to the fore in this context.

<2>**Discernment**</2>

The virtue of discernment brings sensitive insight, astute judgment, and understanding to bear on action. Discernment involves the ability to make fitting judgments and reach decisions without being unduly influenced by extraneous considerations, fears, personal attachments, and the like. Some writers closely associate discernment with practical wisdom, or *phronesis,* to use Aristotle's term. A person of practical wisdom knows which ends to choose, knows how to realize them in particular circumstances, and carefully selects from among the range of possible actions, while keeping emotions within proper bounds. In Aristotle's model, the practically wise person understands how to act with the right intensity of feeling, in just the right way, at just the right time, with a proper balance of reason and desire.[28]

A discerning person is disposed to understand and perceive what circumstances demand in the way of human responsiveness. For example, a discerning physician will see when a despairing patient needs comfort rather than privacy, and vice versa. If comfort is the right choice, the discerning physician

will find the right type and level of consolation to be helpful rather than intrusive. If a rule guides action in a particular case, seeing *how* to best follow the rule involves a form of discernment that is independent of seeing *that* the rule applies.

The virtue of discernment thus involves understanding both that and how principles and rules apply. For instance, acts of respect for autonomy and beneficence will vary in health care contexts, and the ways in which clinicians discerningly implement these principles in the care of patients will be as different as the many ways in which devoted parents care for their children.

<2>**Trustworthiness**</2>

Virtues, Annette Baier maintains, "are personal traits that contribute to a good climate of trust between people, when trust is taken to be acceptance of being, to some degree and in some respects, in another's power."[29] Trust is a confident belief in and reliance on the moral character and competence of another person, often a person with whom one has an intimate or established relationship. Trust entails a confidence that another will reliably act with the right motives and feelings and in accordance with appropriate moral norms.[30] To be *trustworthy* is to warrant another's confidence in one's character and conduct.

Traditional ethical theories rarely mention either trust or trustworthiness. However, Aristotle took note of one important aspect of trust and trustworthiness. He maintained that when relationships are voluntary and among intimates, by contrast to legal relationships among strangers, it is appropriate for the law to forbid lawsuits for harms that occur. Aristotle reasoned that intimate relationships involving "dealings with one another as good and trustworthy" hold persons together more than "bonds of justice" do.[31]

Nothing is more valuable in health care organizations than the maintenance of a culture of trust. Trust and trustworthiness are essential when patients are vulnerable and place their hope and their confidence in health care professionals. A true climate of trust is endangered in contemporary health care institutions, as evidenced by the number of medical malpractice suits and adversarial relations between health care professionals and the public. Overt distrust has been engendered by mechanisms of managed care, because of the incentives some health care organizations create for physicians to limit the amount and kinds of care they provide to patients. Appeals have increased for ombudsmen, patient advocates, legally binding "directives" to physicians, and the like. Among the contributing causes of the erosion of a climate of trust are the loss of intimate contact between physicians and patients, the increased use of specialists, the lack

of adequate access to adequate healthcare insurance, and the growth of large, impersonal, and bureaucratic medical institutions.[32]

<2>**Integrity**</2>

Some writers in bioethics hold that the primary virtue in health care is integrity.[33] People often justify their actions or refusals to act on grounds that they would otherwise compromise or sacrifice their integrity. Later in this chapter we discuss appeals to integrity as invocations of *conscience,* but we confine attention at present to the virtue of integrity.

The central place of integrity in the moral life is beyond dispute, but what the term means is less clear. In its most general sense, "moral integrity" means soundness, reliability, wholeness, and integration of moral character. In a more restricted sense, the term refers to objectivity, impartiality, and fidelity in adherence to moral norms. Accordingly, the virtue of integrity represents two aspects of a person's character. The first is a coherent integration of aspects of the self—emotions, aspirations, knowledge, and the like—so that each complements and does not frustrate the others. The second is the character trait of being faithful to moral values and standing up in their defense when necessary. A person can lack moral integrity in several respects—for example, through hypocrisy,

insincerity, bad faith, and self-deception. These vices represent breaks in the connections among a person's moral convictions, emotions, and actions. The most common deficiency is probably a lack of sincerely and firmly held moral convictions, but no less important is the failure to act consistently on the moral beliefs that one does hold.

Problems in maintaining integrity may also arise from a conflict of moral norms, or from moral demands that require persons to halt or abandon personal goals and projects. Persons may experience a sense of loss of their autonomy and feel violated by the demand to sacrifice their personal commitments and objectives.[34] For example, if a nurse is the only person in her family who can properly manage her mother's health, health care, prescription medications, nursing home arrangements, explanations to relatives, and negotiations with physicians, little time may be left for her personal projects and commitments. Such situations can deprive persons of the liberty to structure and integrate their lives as they choose. If a person has structured his or her life around personal goals that are ripped away by the needs and agendas of others, a loss of personal integrity occurs.

Problems of professional integrity often center on wrongful conduct in professional life. Because breaches of professional integrity involve violations of

professional standards, they are often viewed as violations of the rules of professional associations, codes of medical ethics, or medical traditions,[35] but this vision needs to be broadened. Breaches of professional integrity also occur when a physician prescribes a drug that is no longer recommended for the outcome needed, enters into a sexual relationship with a patient, or follows a living will that calls for a medically inappropriate intervention.

Sometimes conflicts arise between a person's sense of moral integrity and what is required for professional integrity. Consider medical practitioners who, because of their religious commitments to the sanctity of life, find it difficult to participate in decisions not to do everything possible to prolong life. To them, participating in removing ventilators and intravenous fluids from patients, even from patients with a clear advance directive, violates their moral integrity. Their commitments may create morally troublesome situations in which they must either compromise their fundamental commitments or withdraw from the care of the patient. Yet compromise seems what a person, or an organization, of integrity cannot do, because it involves the sacrifice of deep moral commitments.[36]

Health care facilities cannot entirely eliminate these and other problems of staff disagreement and conflicting commitments, but persons with the virtues of patience, humility, and tolerance can help reduce the problems. Situations that

compromise integrity can be ameliorated if participants anticipate the problem before it arises and recognize the limits and fallibility of their personal moral views. Participants in a dispute may also have recourse to consultative institutional processes, such as hospital ethics committees. However, it would be ill-advised to recommend that a person of integrity can and should always negotiate and compromise his or her values in an intrainstitutional confrontation. There is something ennobling and admirable about the person or organization that refuses to compromise beyond a certain carefully considered moral threshold. To compromise below the threshold of integrity is simply to lose it.

<2>**Conscientiousness**</2>

The subject of integrity and compromise leads directly to a discussion of the virtue of conscientiousness and accounts of conscience. An individual acts conscientiously if he or she is motivated to do what is right because it is right, has worked with due diligence to determine what is right, intends to do what is right, and exerts appropriate effort to do so. Conscientiousness is the character trait of acting in this way.

<3>***Conscience and conscientiousness.***</3> *Conscience* has often been viewed as a mental faculty of, and authority for, moral decision making.[37] Slogans such as, "Let your conscience be your guide" suggest that conscience is the final authority in moral justification. However, such a view fails to capture the nature of either conscience or conscientiousness, as the following case presented by Bernard Williams helps us see: Having recently completed his Ph.D. in chemistry, George has not been able to find a job. His family has suffered from his failure: They are short of money, his wife has had to take additional work, and their small children have been subjected to considerable strain, uncertainty, and instability. An established chemist can get George a position in a laboratory that pursues research on chemical and biological weapons. Despite his perilous financial and familial circumstances, George concludes that he cannot accept this position because of his conscientious opposition to chemical and biological warfare. The senior chemist notes that the research will continue no matter what George decides. Furthermore, if George does not take this position, it will be offered to another young man who would vigorously pursue the research. Indeed, the senior chemist confides, his concern about the other candidate's nationalistic fervor and uncritical zeal for research in chemical and biological warfare motivated him to recommend George for the job. George's wife is puzzled and hurt by George's

reaction. She sees nothing wrong with the research. She is profoundly concerned about their children's problems and the instability of their family. Nonetheless, George forgoes this opportunity both to help his family and to prevent a destructive fanatic from obtaining the position. He says his conscience stands in the way.[38]

Conscience, as this example suggests, is not a special moral faculty or a self-justifying moral authority. It is a form of self-reflection about whether one's acts are obligatory or prohibited, right or wrong, good or bad, virtuous or vicious. It also involves an internal sanction that comes into play through critical reflection. When individuals recognize their acts as violations of an appropriate standard, this sanction often appears as a bad conscience in the form of feelings of remorse, guilt, shame, disunity, or disharmony. A conscience that sanctions conduct in this way does not signify bad moral character. To the contrary, this experience of conscience is most likely to occur in persons of strong moral character and may even be a necessary condition of morally good character.[39] Kidney donors have been known to say, "I had to do it. I couldn't have backed out, not that I had the feeling of being trapped, because the doctors offered to get me out. I just had to do it."[40] Such judgments derive from ethical standards that are sufficiently powerful that violating them would diminish integrity and result in

guilt or shame.[41]

When people claim that their actions are conscientious, they sometimes feel compelled by conscience to resist others' authoritative demands. Instructive examples are found in military physicians who believe they must answer first to their consciences and cannot plead "superior orders" when commanded by a superior officer to commit what they believe to be a moral wrong. Agents sometimes act out of character in order to perform what they judge to be the morally appropriate action. For example, a normally cooperative and agreeable physician may indignantly, but justifiably, protest an insurance company's decision not to cover the costs of a patient's treatment. Such moral indignation and outrage can be appropriate and admirable.

<3>***Conscientious refusals.***</3> Conscientious objections and refusals by physicians, nurses, pharmacists, and other health care professionals raise difficult issues for public policy, professional organizations, and health care institutions. Examples are found in a physician's refusal to honor a patient's legally valid advance directive to withdraw artificial nutrition and hydration, a nurse's refusal to participate in an abortion or sterilization procedure, and a pharmacist's refusal to fill a prescription for an emergency contraception.

There are good reasons to promote conscientiousness and to respect acts of conscience.

Respecting conscientious refusals in health care is an important value, and these refusals should be accommodated unless there are overriding conflicting values. Banning or greatly restricting conscientious refusals in health care could have several negative consequences. It could, according to one analysis, negatively affect the type of people who choose medicine as their vocation and how practicing physicians view and discharge professional responsibilities. It could also foster "callousness" and encourage physicians' "intolerance" of diverse moral beliefs among their patients (and perhaps among their colleagues as well).[42] These possible negative effects are somewhat speculative, but they merit consideration in forming institutional and public policies.

Also meriting consideration is that some conscientious refusals adversely affect patients' and others' legitimate interests in (1) timely access, (2) safe and effective care, (3) respectful care, (4) nondiscriminatory treatment, (5) care that is not unduly burdensome, and (5) privacy and confidentiality. Hence, public policy, professional associations, and healthcare institutions should seek to recognize and accommodate conscientious refusals as long as they can do so without seriously

compromising patients' rights and interests. The metaphor of *balancing* professionals' and patients' rights and interests is commonly used to guide efforts to resolve such conflicts, but it offers limited guidance and no single model of appropriate response covers all cases.[43]

Institutions such as hospitals and pharmacies can often ensure the timely performance of needed or requested services while allowing conscientious objectors not to perform those services.[44] However, ethical problems arise when, for example, a pharmacist refuses, on grounds of complicity in moral wrongdoing, to transfer a consumer's prescription or to inform the consumer of pharmacies that would fill the prescription. According to one study, only 86% of U.S. physicians surveyed regard themselves as obligated to disclose information about morally controversial medical procedures to patients, and only 71% of U.S. physicians recognize an obligation to refer patients to another physician for such controversial procedures.[45] Given these results, millions of patients in the U.S. may be under the care of physicians who do not recognize these obligations or are undecided about them.

At a minimum, in our view, health care professionals have an ethical duty to inform prospective employers and prospective patients, clients, and consumers in advance of their personal conscientious objections to performing vital services.

Likewise, they have an ethical duty to disclose options for obtaining legal, albeit morally controversial, services; and sometimes they have a duty to provide a referral for those services. They also may have a duty to perform the services in emergency circumstances when the patient is at risk of adverse health effects and a timely referral is not possible.[46]

Determining the appropriate scope of protectable conscientious refusals is a vexing problem, particularly when those refusals involve expansive notions of what counts as assisting or participating in the performance of a personally objectionable action. Such expansive notions sometimes include actions that are only indirectly related to the objectionable procedure. For example, some nurses have claimed conscientious exemption from all forms of participation in the care of patients having an abortion or sterilization, including filling out admission forms or providing post-procedure care. It is often difficult and sometimes impractical for institutions to pursue their mission while exempting objectors to such broadly delineated forms of participation in a procedure.

<1>Moral Ideals</1>

We argued in Chapter 1 that norms of obligation in the common morality constitute a moral minimum of requirements that govern everyone. These

standards differ from extraordinary moral standards that are not *required* of any person. Moral ideals such as extraordinary generosity are rightly admired and approved by all morally committed persons, and in this respect they are part of the common morality. Extraordinary moral standards come from a morality of aspiration in which individuals, communities, or institutions adopt high ideals not required of others. We can praise and admire those who live up to these ideals, but we cannot blame or criticize persons who do not pursue the ideals.

A straightforward example of a moral ideal in biomedical ethics is found in "expanded access" or "compassionate use" programs that—prior to regulatory approval—authorize access to an investigational drug or device for patients with a serious or immediately life-threatening disease or condition. These patients have exhausted available therapeutic options and are situated so that they cannot participate in a clinical trial of a comparable investigational product. Although it is compassionate and justified to provide some investigational products for therapeutic use, it is generally not obligatory to do so. These programs are compassionate, nonobligatory, and motivated by a goal of providing a good to these patients. The self-imposed moral commitment by the sponsors of the investigational product usually springs from moral ideals of communal service or

providing a benefit to individual patients. (See Chapter 6, pp. •••–•••, for additional discussion of expanded access programs.)

With the addition of moral ideals, we now have four categories pertaining to moral action: (1) actions that are right and obligatory (e.g., truth-telling); (2) actions that are wrong and prohibited (e.g., murder and rape); (3) actions that are optional and morally neutral, and so neither wrong nor obligatory (e.g., playing chess with a friend); and (4) actions that are optional but morally meritorious and praiseworthy (e.g., sending flowers to a hospitalized friend). We concentrated on the first two in Chapter 1, occasionally mentioning the third. We now focus exclusively on the fourth.

<2>**Supererogation and Virtue**</2>

Supererogation is a category of moral ideals pertaining principally to ideals of action, but it has important links both to virtues and to Aristotelian ideals of moral excellence.[47] The etymological root of *supererogation* means paying or performing beyond what is owed or, more generally, doing more than is required. This notion has four essential conditions. First, supererogatory acts are optional and neither required nor forbidden by common-morality standards of obligation. Second, supererogatory acts exceed what the common morality of obligation

demands, but at least some moral ideals are *endorsed* by all persons committed to the common morality. Third, supererogatory acts are intentionally undertaken to promote the welfare interests of others. Fourth, supererogatory acts are morally good and praiseworthy in themselves and are not merely acts undertaken with good intentions.

Despite the first condition, individuals who act on moral ideals do not always *consider* their actions to be morally optional. Many heroes and saints describe their actions in the language of *ought, duty,* and *necessity:* "I had to do it." "I had no choice." "It was my duty." The point of this language is to express a personal sense of obligation, not to state a general obligation. The agent accepts, as a pledge or assignment of personal responsibility, a norm that lays down what ought to be done. At the end of Albert Camus's *The Plague,* Dr. Rieux decides to make a record of those who fought the pestilence. It is to be a record, he says, of "what *had to be done* . . . despite their personal afflictions, by all who, while unable to be saints but refusing to bow down to pestilences, strive their utmost to be healers."[48] Such healers accept exceptional risks and thereby exceed the obligations of the common morality and of professional associations and traditions.

Many supererogatory acts would be morally obligatory were it not for some abnormal adversity or risk in the face of which the individual elects not to invoke an allowed exemption based on the adversity or risk.[49] If persons have the strength of character that enables them to resist extreme adversity or assume additional risk to fulfill their own conception of their obligations, it makes sense to accept their view that they are under a self-imposed obligation. The hero who says, "I was only doing my duty," is speaking as one who accepts a standard of moral excellence. This hero does not make a mistake in regarding the action as personally required and can view failure as grounds for guilt, although no one else is free to evaluate the act as a moral failure.

Despite the language of "exceptional" and "extreme adversity," not all supererogatory acts are extraordinarily arduous, costly, or risky. Examples of less demanding forms of supererogation include generous gift-giving, volunteering for public service, forgiving another's costly error, and acting from exceptional kindness. Many everyday actions exceed obligation without reaching the highest levels of supererogation. For example, a nurse may put in extra hours of work during the day and return to the hospital at night to visit patients. This nurse's actions are morally excellent, but he or she does not thereby qualify as a saint or hero.

Often we are uncertain whether an action exceeds obligation because the boundaries of obligation and supererogation are ill defined. There may be no clear norm of action, only a virtue of character at work. For example, what is a nurse's role obligation to desperate, terminally ill patients who cling to the nurse for comfort in their few remaining days? If the obligation is that of spending forty hours a week conscientiously fulfilling a job description, the nurse exceeds that obligation by just a few off-duty visits to patients. If the obligation is simply to help patients overcome burdens and meet a series of challenges, a nurse who does so while displaying extraordinary patience, fortitude, and friendliness well exceeds the demands of obligation. Health care professionals sometimes live up to what would ordinarily be a role obligation (such as complying with basic standards of care), while making a sacrifice or taking an additional risk. These cases exceed obligation, but they may not qualify as supererogatory actions.

<2>**The Continuum from Obligation to Supererogation**</2>

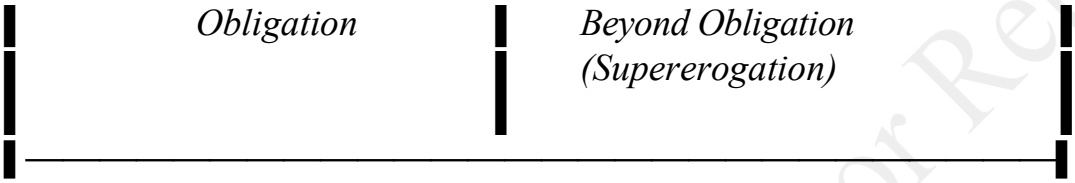
Our analysis may seem to suggest that actions should be classified as either obligatory or beyond the obligatory. The better view, however, is that actions sometimes do not fit neatly into these categories because they fall between the two. Common morality distinctions and ethical theory are not precise enough to

determine whether all actions are morally required or morally elective. This problem is compounded in professional ethics, because professional roles engender obligations that do not bind persons who do not occupy the relevant professional roles. Hence, the two "levels" of the obligatory and the supererogatory lack sharp boundaries both in the common morality and in professional ethics.

Actions may be strictly obligatory, beyond the obligatory, or somewhere between these two classifications. A continuum runs from strict obligation (such as the obligations in the core principles and rules in the common morality) through weaker obligations that are still within the scope of the morally required (such as double checking one's professional work to be sure that no medical errors have occurred), and on to the domain of the morally nonrequired and the exceptionally virtuous. The nonrequired starts with low-level supererogation, such as walking a visitor lost in a hospital's corridors to a doctor's office. Here an absence of generosity or kindness in helping someone may constitute a small defect in the moral life, rather than a failure of obligation. The continuum ends with high-level supererogation, such as heroic acts of self-sacrifice, as in highly risky

medical self-experimentation. A continuum exists on each level. The following diagram represents the continuum.

<Comp: set diagram below as per design in 7/e, p. 47, using all solid lines with no breaks.>



<end>

This continuum moves from strict obligation to the most arduous and elective moral ideal. The horizontal line represents a continuum with rough, not sharply defined, breaks. The middle vertical line divides the two general categories, but is not meant to indicate a sharp break. Accordingly, the horizontal line expresses a continuum across the four lower categories and expresses the scope of the common morality's reach into the domains of both moral obligation and nonobligatory moral ideals.

Joel Feinberg argues that supererogatory acts are "located on an altogether different scale than obligations."[50] The preceding diagram suggests that this comment is correct in one respect, but potentially incorrect in another. The right half of the diagram is not scaled byobligation, whereas the left half is. In this

respect, Feinberg's comment is correct. However, the full horizontal line is connected by a single scale of moral value in which the right is continuous with the left. For example, obligatory acts of beneficence and supererogatory acts of beneficence are on the same scale because they are morally of the same kind. The domain of supererogatory ideals is continuous with the domain of norms of obligation by *exceeding* those obligations in accordance with the several defining conditions of supererogation listed previously.

<2>**The Place of Ideals in Biomedical Ethics**</2>

Many beneficent actions by health care professionals straddle the territory marked in the preceding diagram between *Obligation* and *Beyond Obligation* (in particular, the territory between [2] and [3]). Matters become more complicated when we introduce the distinction discussed in Chapter 1 between professional obligations and obligations incumbent on everyone. Many moral duties established by roles in health care are not moral obligations for persons not in these roles. These duties in medicine and nursing are profession-relative, and some are role obligations even when not formally stated in professional codes. For example, the expectation that physicians and nurses will encourage and cheer

despondent patients is a profession-imposed obligation, though not one typically incorporated in a professional code of ethics.

Some customs in the medical community are not well established as obligations, such as the belief that physicians and nurses should efface self-interest and take risks in attending to patients. The nature of "obligations" when caring for patients with SARS (severe acute respiratory syndrome), Ebola, and other diseases with a significant risk of transmission and a significant mortality rate has been controversial, and professional codes and medical association pronouncements have varied.[51] One of the strongest statements of physician duty appeared in the previously mentioned original 1847 Code of Medical Ethics of the American Medical Association (AMA): "when pestilence prevails, it is their [physicians'] duty to face the danger, and to continue their labours for the alleviation of the suffering, even at the jeopardy of their own lives."[52] This statement was retained in subsequent versions of the AMA code until the 1950s, when the statement was eliminated, perhaps in part because of a false sense of the permanent conquest of dangerous contagious diseases.

We usually cannot resolve controversies about duty in face of risk without determining the level of risk—in terms of both the probability and the seriousness of harm—that professionals are expected to assume and setting a threshold

beyond which the level of risk is so high that it renders action optional rather than obligatory. The profound difficulty of drawing this line should help us appreciate why some medical associations have urged their members to be courageous and treat patients with potentially lethal infectious diseases, while other associations have advised their members that treatment is optional in many circumstances.[53] Still others have taken the view that both virtue and obligation converge to the conclusion that health care professionals should set aside self-interest, within limits, and that the health care professions should take actions to ensure appropriate care.[54]

Confusion occasionally arises about such matters because of the indeterminate boundaries of what is required in the common morality, what is or should be required in professional communities, and what is a matter of moral character beyond the requirements of moral obligations. In many cases it is doubtful that health care professionals fail to discharge *moral obligations* when they fall short of the highest standards in the profession.

<1>Moral Excellence</1>

Aristotelian ethical theory closely connects moral excellence to moral character, moral virtues, and moral ideals. Aristotle succinctly presents this idea: "A truly

good and intelligent person . . . from his resources at any time will do the finest actions he can, just as a good general will make the best use of his forces in war, and a good shoemaker will produce the finest shoe he can from the hides given him, and similarly for all other craftsmen."[55] This passage captures the demanding nature of Aristotle's theory by contrast to ethical theories that focus largely or entirely on the moral minimum of obligations.

The value of this vision of excellence is highlighted by John Rawls, in conjunction with what he calls the "Aristotelian principle":

> <EXT>The excellences are a condition of human flourishing; they are goods from everyone's point of view. These facts relate them to the conditions of self-respect, and account for their connection with our confidence in our own value. . . . [T]he virtues are [moral] excellences. . . . The lack of them will tend to undermine both our self-esteem and the esteem that our associates have for us.[56]</EXT>

We now draw on this general background in Aristotelian theory and on our prior analysis of moral ideals and supererogation for an account of moral excellence.

<2>**The Idea of Moral Excellence** </2>

We begin with four considerations that motivate us to treat this subject. First, we hope to overcome an undue imbalance in contemporary ethical theory and bioethics that results from focusing narrowly on the moral minimum of

obligations while ignoring supererogation and moral ideals.[57] This concentration dilutes the moral life, including our expectations for ourselves, our close associates, and health professionals. If we expect only the moral minimum of obligation, we may lose an ennobling sense of moral excellence. A second and related motivation is our hope to overcome a suppressed skepticism in contemporary ethical theory concerning high ideals in the moral life. Some influential writers note that high moral ideals must compete with other goals and responsibilities in life, and consequently that these ideals can lead persons to neglect other matters worthy of attention, including personal projects, family relationships, friendships, and experiences that broaden outlooks.[58] A third motivation concerns what we call in Chapter 9 the *criterion of comprehensiveness* in an ethical theory. Recognizing the value of moral excellence allows us to incorporate a broad range of moral virtues and forms of supererogation beyond the obligations, rights, and virtues that comprise ordinary morality. Fourth, a model of moral excellence merits pursuit because it indicates what is worthy of aspiration. Morally exemplary lives provide ideals that help guide and inspire us to higher goals and morally better lives.

<2>**Aristotelian Ideals of Moral Character**</2>

Aristotle maintained that we acquire virtues much as we do skills such as carpentry, playing a musical instrument, and cooking.[59] Both moral and nonmoral skills require training and practice. Obligations play a less central role in his account. Consider, for example, a person who undertakes to expose scientific fraud in an academic institution. It is easy to frame this objective as a matter of obligation, especially if the institution has a policy on fraud. However, suppose this person's correct reports of fraud to superiors are ignored, and eventually her job is in jeopardy and her family receives threats. At some point, she has fulfilled her obligations and is not morally required to pursue the matter further. However, if she does persist, her continued pursuit would be praiseworthy, and her efforts to bring about institutional reform could even reach heroic dimensions. Aristotelian theory could and should frame this situation in terms of the person's level of commitment, the perseverance and endurance shown, the resourcefulness and discernment in marshalling evidence, and the courage, as well as the decency and diplomacy displayed in confronting superiors.

An analogy to education illustrates why setting goals beyond the moral minimum is important, especially when discussing moral character. Most of us are trained to aspire to an ideal of education. We are taught to prepare ourselves as best we can. No educational aspirations are too high unless they exceed our

abilities and cannot be attained. If we perform at a level below our educational potential, we may consider our achievement a matter of disappointment and regret even if we obtain a university degree. As we fulfill our aspirations, we sometimes expand our goals beyond what we had originally planned. We think of getting another degree, learning another language, or reading widely beyond our specialized training. However, we do not say at this point that we have an *obligation* to achieve at the highest possible level we can achieve.

The Aristotelian model suggests that moral character and moral achievement are functions of self-cultivation and aspiration. Goals of moral excellence can and should enlarge as moral development progresses. Each individual should seek to reach a level as elevated as his or her ability permits, not as a matter of *obligation* but of *aspiration*. Just as persons vary in the quality of their performances in athletics and medical practice, so too in the moral life some persons are more capable than others and deserve more acknowledgment, praise, and admiration. Some persons are sufficiently advanced morally that they exceed what persons less well developed are able to achieve.

Wherever a person is on the continuum of moral development, there will be a goal of excellence that exceeds what he or she has already achieved. This potential to revise our aspirations is centrally important in the moral life. Consider

a clinical investigator who uses human subjects in research but who asks only, "What am I obligated to do to protect human subjects?" This investigator's presumption is that once this question has been addressed by reference to a checklist of obligations (for example, government regulations), he or she can ethically proceed with the research. By contrast, in the model we are proposing, this approach is only the starting point. The most important question is, "How could I conduct this research to maximally protect and minimally inconvenience subjects, commensurate with achieving the objectives of the research?" Evading this question indicates that one is morally less committed than one could and probably should be.

The Aristotelian model we have sketched does not expect perfection, only that persons strive toward perfection. This goal might seem impractical, but moral ideals truly can function as practical instruments. As *our* ideals, they motivate us and set out a path that we can climb in stages, with a renewable sense of progress and achievement.

<2>**Exceptional Moral Excellence: Saints, Heroes, and Others**</2>

Extraordinary persons often function as models of excellence whose examples we aspire to follow. Among the many models, the moral hero and the moral saint are the most celebrated.

The term *saint* has a long history in religious traditions where a person is recognized for exceptional holiness, but, like *hero*, the term *saint* has a secular moral use where a person is recognized for exceptional action or virtue. Excellence in other-directedness, altruism, and benevolence are prominent features of the moral saint.[60] Saints do their duty and realize moral ideals where most people would fail to do so, and saintliness requires regular fulfillment of duty and realization of ideals over time. It also demands consistency and constancy. We likely cannot make an adequate or final judgment about a person's moral saintliness until the record is complete. By contrast, a person may become a moral hero through a single exceptional action, such as accepting extraordinary risk while discharging duty or realizing ideals. The hero resists fear and the desire for self-preservation in undertaking risky actions that most people would avoid, but the hero also may lack the constancy over a lifetime that distinguishes the saint.

Many who serve as moral models or as persons from whom we draw moral inspiration are not so advanced morally that they qualify as saints or heroes. We

learn about good moral character from persons with a limited repertoire of exceptional virtues, such as conscientious health professionals. Consider, for example, John Berger's biography of English physician John Sassall (the pseudonym Berger used for physician John Eskell), who chose to practice medicine in a poverty-ridden, culturally deprived country village in a remote region of northern England. Under the influence of works by Joseph Conrad, Sassall chose this village from an "ideal of service" that reached beyond "the average petty life of self-seeking advancement." Sassall was aware that he would have almost no social life and that the villagers had few resources to pay him, to develop their community, and to attract better medicine, but he focused on their needs rather than his. Progressively, Sassall grew morally as he interacted with members of the community. He developed a deep understanding of, and profound respect for, the villagers. He became a person of exceptional caring, devotion, discernment, conscientiousness, and patience when taking care of the villagers. His moral character deepened year after year. People in the community, in turn, trusted him under adverse and personally difficult circumstances.[61]

From exemplary lives such as that of John Sassall and from our previous analysis, we can extract four criteria of moral excellence.[62] First, Sassall is faithful to a *worthy moral ideal* that he keeps constantly before him in making judgments

and performing actions. The ideal is deeply devoted service to a poor and needy community. Second, he has a *motivational structure* that conforms closely to our earlier description of the motivational patterns of virtuous persons who are prepared to forgo certain advantages for themselves in the service of a moral ideal. Third, he has an *exceptional moral character;* that is, he possesses moral virtues that dispose him to perform supererogatory actions of a high order and quality.[63] Fourth, he is a *person of integrity*—both moral integrity and personal integrity—and thus is not overwhelmed by distracting conflicts, self-interest, or personal projects in making judgments and performing actions.

These four conditions are jointly sufficient conditions of *moral excellence.* They are also relevant, but not sufficient, conditions of both moral saintliness and moral heroism. John Sassall does not face extremely difficult tasks, a high level of risk, or deep adversity (although he faces some adversity including his bi-polar condition), and these are typically the sorts of conditions that contribute to making a person a saint or a hero. Exceptional as he is, Sassall is neither a saint nor a hero. To achieve this elevated status, he would have to satisfy additional conditions.

Much admired (though sometimes controversial) examples of moral saints acting from a diverse array of religious commitments are Mahatma Gandhi, Florence Nightingale, Mother Teresa, the 14th Dalai Lama (religious name:

Tenzin Gyatso), and Albert Schweitzer. Many examples of moral saints are also found in secular contexts where persons are dedicated to lives of service to the poor and downtrodden. Clear examples are persons motivated to take exceptional risks to rescue strangers.[64] Examples of prominent moral heroes include soldiers, political prisoners, and ambassadors who take substantial risks to save endangered persons by acts such as falling on hand grenades to spare comrades and resisting political tyrants.

Scientists and physicians who experiment on themselves to generate knowledge that may benefit others may be heroes. There are many examples: Daniel Carrion injected blood into his arm from a patient with verruga peruana (an unusual disease marked by many vascular eruptions of the skin and mucous membranes as well as fever and severe rheumatic pains), only to discover that it had given him a fatal disease (Oroya fever). Werner Forssman performed the first heart catheterization on himself, walking to the radiological room with the catheter sticking into his heart.[65] Daniel Zagury injected himself with an experimental AIDS vaccine, maintaining that his act was "the only ethical line of conduct."[66]

A person can qualify as a moral hero or a moral saint only if he or she meets some combination of the previously listed four conditions of moral

excellence. It is too demanding to say that a person must satisfy all four conditions to qualify as a moral hero, but a person must satisfy all four to qualify as a moral saint. This appraisal does not imply that moral saints are more valued or more admirable than moral heroes. We are merely proposing conditions of moral excellence that are more stringent for moral saints than for moral heroes.[67]

To pursue and test this analysis, consider two additional cases.[68] First, reflect on physician David Hilfiker's *Not All of Us Are Saints,* which offers an instructive model of very exceptional but not quite saintly or heroic conduct in his efforts to practice "poverty medicine" in Washington, DC.[69] His decision to leave a rural medical practice in the Midwest to provide medical care to the very poor, including the homeless, reflected both an ambition and a felt obligation. Many health problems he encountered stemmed from an unjust social system, in which his patients had limited access to health care and to other basic social goods that contribute to health. He experienced severe frustration as he encountered major social and institutional barriers to providing poverty medicine, and his patients were often difficult and uncooperative. His frustrations generated stress, depression, and hopelessness, along with vacillating feelings and attitudes including anger, pain, impatience, and guilt. Exhausted by his sense of endless needs and personal limitations, his wellspring of compassion failed to respond one

day as he thought it should: "Like those whom on another day I would criticize harshly, I harden myself to the plight of a homeless man and leave him to the inconsistent mercies of the city police and ambulance system. Numbness and cynicism, I suspect, are more often the products of frustrated compassion than of evil intentions."

Hilfiker declared that he is "anything but a saint." He considered the label "saint" to be inappropriate for people, like himself, who have a safety net to protect them. Blaming himself for "selfishness," he redoubled his efforts, but recognized a "gap between who I am and who I would like to be," and he considered that gap "too great to overcome." He abandoned "in frustration the attempt to be Mother Teresa," observing that "there are few Mother Teresas, few Dorothy Days who can give everything to the poor with a radiant joy." Hilfiker did consider many of the people with whom he worked day after day as heroes, in the sense that they "struggle against all odds and survive; people who have been given less than nothing, yet find ways to give."

Second, in *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger,* psychiatrist and anthropologist Arthur Kleinman presents half-a-dozen real-life stories about people who, as the book's subtitle suggests, attempt to live morally in the context of unpredictability and hazard.[70] A story that

provided the impetus for his book portrays a woman he names Idi Bosquet-Remarque, a French-American who for more than fifteen years was a field representative for several different international aid agencies and foundations, mainly in sub-Saharan Africa. Her humanitarian assistance, carried out almost anonymously, involved working with vulnerable refugees and displaced women and children as well as with the various professionals, public officials, and others who interacted with them. Kleinman presents her as a "moral exemplar," who expressed "our finest impulse to acknowledge the suffering of others and to devote our lives and careers to making a difference (practically and ethically) in their lives, even if that difference must be limited and transient."

At times Bosquet-Remarque was dismayed by various failures, including her own mistakes. She despaired about the value of her work given the overwhelming odds against the people she sought to help, and she recognized some truth in several criticisms of her humanitarian assistance. Faced with daunting obstacles, she persisted because of her deep commitment but eventually experienced physical and emotional burnout, numbness, and demoralization. Nevertheless, she returned to the field because of her deep commitment to her work. Bosquet-Remarque recognized that her motives might be mixed. In addition to her altruism and compassion, she also could have been working out

family guilt or seeking to liberate her soul. Despite the ever-present risk of serious injury and even death from violence, she was uncomfortable with the image of the humanitarian worker as "hero."

After Bosquet-Remarque's death in an automobile accident, Kleinman informed her family that he wanted to tell her story. Her mother requested that her daughter not be identified by name: "That way, you will honor what she believed in. Not saints or heroes, but ordinary nameless people doing what they feel they must do, even in extraordinary situations. As a family, we believe in this too."

These observations about ordinary persons who act in extraordinary ways are also relevant to what has been called moral heroism in living organ and tissue donation—a topic to which we now turn.

<2>**Living Organ Donation**</2>

In light of our moral account thus far, how should we assess a person's offer to donate a kidney to a friend or a stranger?

Health care professionals frequently function as moral gatekeepers to determine who may undertake living donation of organs and tissues for transplantation. Blood donation raises few questions, but in cases of bone marrow donation and the donation of kidneys or portions of livers or lungs, health care

professionals must consider whether, when, and from whom to invite, encourage, accept, and effectuate donation. Living organ donation raises challenging ethical issues because the transplant team subjects a healthy person to a variably risky surgical procedure, with no medical benefit to him or her. It is therefore appropriate for transplant teams to probe prospective donors' competence to make such decisions and their understanding, voluntariness, and motives.

Historically, transplant teams were suspicious of living, genetically unrelated donors—particularly of strangers and mere acquaintances but, for a long time, even of emotionally related donors such as spouses and friends. This suspicion had several sources, including concerns about donors' motives and worries about their competence to decide, understanding of the risks, and voluntariness in reaching their decisions. This suspicion increased in cases of nondirected donation, that is, donation not to a particular known individual, but to anyone in need. Such putatively altruistic decisions to donate seemed to require heightened scrutiny. However, in contrast to some professionals' attitudes,[71] a majority of the public in the United States believes that the gift of a kidney to a stranger is reasonable and proper and that, in general, the transplant team should accept it.[72] A key reason is that the offer to donate a kidney whether by a friend, an acquaintance, or a stranger typically does not involve such high risks that

serious questions should be triggered about the donor's competence, understanding, voluntariness, or motivation.[73]

Transplant teams can and should decline some heroic offers of organs for moral reasons, even when the donors are competent, their decisions informed and voluntary, and their moral excellence beyond question. For instance, transplant teams have good grounds to decline a mother's offer to donate her heart to save her dying child, because the donation would involve others in directly causing her death. A troublesome case arose when an imprisoned, 38-year-old father who had already lost one of his kidneys wanted to donate his remaining kidney to his 16-year-old daughter whose body had already rejected one kidney transplant.[74] The family insisted that medical professionals and ethics committees had no right to evaluate, let alone reject, the father's act of donation. However, questions arose about the voluntariness of the father's offer (in part because he was in prison), about the risks to him (many patients without kidneys do not thrive on dialysis), about the probable success of the transplant (because of his daughter's problems with her first transplant), and about the costs to the prison system (approximately $40,000 to $50,000 a year for dialysis for the father if he donated the remaining kidney).

We propose that society and health care professionals start with the presumption that living organ donation is praiseworthy but optional. Transplant teams need to subject their criteria for selecting and accepting living donors to public scrutiny to ensure that the teams do not inappropriately use their own values about sacrifice, risk, and the like, as the basis for their judgments.[75] Policies and practices of encouraging prospective living donors are ethically acceptable as long as they do not turn into undue influence or coercion. For instance, it is ethically acceptable to remove financial disincentives for potential donors, such as the costs of post-operative care, expenses associated with travel and accommodations, and the loss of wages while recovering from donation. It is also ethically acceptable to provide a life-insurance policy to reduce risks to the family of the living donor.[76] In the final analysis, live organ donors may not rise to the level of heroes, depending on the risks involved, but many embody a moral excellence that merits society's praise, as well as acceptance by transplant teams in accord with defensible criteria. (In Chapter 9, in each major section, we analyze from several perspectives the case of a father who is reluctant, at least partly because of a lack of courage, to donate a kidney to his dying daughter.)

<1>CONCLUSION</1>

In this chapter we have moved to a moral territory distinct from the principles, rules, obligations, and rights treated in Chapter 1. We have sought to render the two domains consistent without assigning priority to one over the other. We have discussed how standards of virtue and character are closely connected to other moral norms, in particular to moral ideals and aspirations of moral excellence that enrich the rights, principles, and rules discussed in Chapter 1. There is no reason to consider one domain inferior to or derivative from the other, and there is reason to believe that these categories all have a significant place in the common morality.

Still other domains of the moral life of great importance in biomedical ethics remain unaddressed. In Chapter 3 we turn to the chief domain not yet analyzed: moral status.

<N-1>**NOTES**</N-1>

<N>[1] For relevant literature on the subjects discussed in Chapter 2 and in the last section of Chapter 9, see Stephen Darwall, ed., *Virtue Ethics* (Oxford: Blackwell Publishing, 2003); Roger Crisp and Michael Slote, eds., *Virtue Ethics* (Oxford: Oxford University Press, 1997); Roger Crisp, ed., *How Should One Live? Essays on the Virtues* (Oxford: Oxford University

Press, Clarendon, 1996); and Daniel Statman, ed., *Virtue Ethics: A Critical Reader* (Washington, DC: Georgetown University Press, 1997). Many constructive discussions of virtue theory are indebted to Aristotle. For a range of treatments, see Julia Annas, *Intelligent Virtue* (New York: Oxford University Press, 2011) and Annas, "Applying Virtue to Ethics," *Journal of Applied Philosophy* 32 (2015): 1–14; Christine Swanton, *Virtue Ethics: A Pluralistic View* (New York: Oxford University Press, 2003); Nancy Sherman, *The Fabric of Character: Aristotle's Theory of Virtue* (Oxford: Clarendon, 1989); Alasdair MacIntyre, *After Virtue: A Study in Moral Theory,* 3rd ed. (Notre Dame, IN: University of Notre Dame Press, 2007) and *Dependent Rational Animals: Why Human Beings Need the Virtues* (Chicago: Open Court, 1999); Timothy Chappell, ed., *Values and Virtues: Aristotelianism in Contemporary Ethics* (Oxford: Clarendon, 2006); and Robert Merrihew Adams, *A Theory of Virtue: Excellence in Being for the Good* (Oxford: Clarendon, 2006), and Adams, "A Theory of Virtue: Response to Critics," *Philosophical Studies* 148 (2010): 159–65.

[2] Bentham, *Deontology or the Science of Morality* (Chestnut Hill, MA: Adamant Media Corporation, 2005; reprinted in the Elibron Classics Series of the 1834 edition, originally published in London by Longman et al., 1834), p. 196.

[3] This sense of "virtue" is intentionally broad. We do not require, as did Aristotle, that virtue involve habituation rather than a natural character trait. See *Nicomachean Ethics,* trans. Terence Irwin (Indianapolis, IN: Hackett Publishing, 1985), 1103ª18–19. Nor do we follow St. Thomas Aquinas (relying on a formulation by Peter Lombard), who additionally held that virtue is a good quality of mind by which we live rightly and therefore cannot be put to bad use. See *Treatise on the Virtues* (from *Summa Theologiae,* I–II), Question 55, Arts. 3–4. We treat problems of the definition of "virtue" in more detail in Chapter 9.

[4] This definition is the primary use reported in the *Oxford English Dictionary* (*OED*). It is defended philosophically by Alan Gewirth, "Rights and Virtues," *Review of Metaphysics* 38 (1985): 751; and Richard B. Brandt, "The Structure of Virtue," *Midwest Studies in Philosophy* 13 (1988): 76. See also the consequentialist account in Julia Driver, *Uneasy Virtue* (Cambridge: Cambridge University Press, 2001), esp. chap. 4, and Driver, "Response to my Critics," *Utilitas* 16 (2004): 33–41. Edmund Pincoffs presents a definition of virtue in terms of desirable dispositional qualities of persons, in *Quandaries and Virtues: Against Reductivism in Ethics* (Lawrence, KS: University Press of Kansas, 1986), pp. 9, 73–100. See also MacIntyre, *After Virtue,* chaps. 10–18; and Raanan Gillon, "Ethics Needs Principles," *Journal of Medical Ethics* 29 (2003): 307–12, esp. 309.

[5] See the pursuit of this Aristotelian theme in Annas, *Intelligent Virtue,* chap. 5. Elizabeth Anscombe's "Modern Moral Philosophy" (*Philosophy* 33 (1958): 1-19) is the classic mid-twentieth-century paper on the importance for ethics of categories such as character, virtue, the emotions, and Aristotelian ethics, by contrast to moral theories based on moral law, duty, and principles of obligation.

[6] This analysis of practices is influenced by Alasdair MacIntyre, *After Virtue,* esp. chap. 14; and Dorothy Emmet, *Rules, Roles, and Relations* (New York: St. Martin's, 1966). See also Justin Oakley and Dean Cocking, *Virtue Ethics and Professional Roles* (Cambridge: Cambridge University Press, 2001); Oakley, "Virtue Ethics and Bioethics," in *The Cambridge Companion to Virtue Ethics*, ed. Daniel C. Russell (Cambridge: Cambridge University Press, 2013), pp. 197–220; and Tom L. Beauchamp, "Virtue Ethics and Conflict of Interest," in *The Future of Bioethics: International Dialogues*, ed. Akira Akabayashi (Oxford: Oxford University Press, 2014), pp. 688-92.

[7] A somewhat similar thesis is defended, in dissimilar ways, in Edmund D. Pellegrino, "Toward a Virtue-Based Normative Ethics for the Health Professions," *Kennedy Institute Ethics Journal* 5 (1995): 253–77. See also John Cottingham, "Medicine, Virtues and Consequences," in *Human Lives: Critical Essays on Consequentialist Bioethics,* ed. David S. Oderberg (New York: Macmillan, 1997); Alan E. Armstrong, *Nursing Ethics: A Virtue-Based Approach* (Houndmills, Eng. and New York: Palgrave Macmillan, 2007); and Jennifer Radden and John Z. Sadler, *The Virtuous Psychiatrist: Character Ethics in Psychiatric Practice* (New York: Oxford University Press, 2010).

[8] Charles L. Bosk, *Forgive and Remember: Managing Medical Failure*, 2nd edition (Chicago: University of Chicago Press, 2003). In addition to the three types of error we mention, Bosk recognizes a fourth type of error: "quasi-normative errors," based on the attending's special protocols. In the Preface to the 2nd edition, he notes that his original book did not stress as much as it should have the problems that were created when normative and quasi-normative breaches were treated in a unitary fashion (p. xxi).

[9] Thomas Percival, *Medical Ethics; or a Code of Institutes and Precepts, Adapted to the Professional Conduct of Physicians and Surgeons* (Manchester, England: S. Russell, 1803), pp. 165–66. This book formed the substantive basis of the first American Medical Association code in 1847.

[10] For this shift, see Gerald R. Winslow, "From Loyalty to Advocacy: A New Metaphor for Nursing," *Hastings Center Rep*ort 14 (June 1984): 32-40; and Helga Kuhse, *Caring: Nurses, Women and Ethics* (Oxford, UK, and Maldon, MA: Blackwell Publishers, 1997), esp. chaps. 1, 2, & 9.

[11] See the virtue-based approach to nursing ethics in Armstrong, *Nursing Ethics: A Virtue-Based Approach.*

[12] Contrast Virginia Held's argument for a sharp distinction between the ethics of care and virtue ethics on the grounds that the former focuses on relationships and the latter on individuals' dispositions: *The Ethics of Care: Personal, Political, and Global* (New York: Oxford University Press, 2006). We are skeptical of her argument, and of the similar view developed by Nel Noddings in "Care Ethics and Virtue Ethics," in *The Routledge Companion to*

Virtue Ethics, ed., Lorraine Besser-Jones and Michael Slote (London and New York: Routledge, 2015), pp. 401-414. Drawing on related themes, Ruth Groenhout challenges the standard taxonomies that lump a feminist ethic of care together with virtue ethics (developed from a non-feminist history); see her "Virtue and a Feminist Ethic of Care," in *Virtues and Their Vices*, ed., Kevin Timpe and Craig A. Boyd (Oxford and New York: Oxford University Press, 2014), pp. 481-501. For an argument closer to ours, see Raja Halwani, "Care Ethics and Virtue Ethics," *Hypatia* 18 (2003): 161-92.

[13] Carol Gilligan, *In a Different Voice* (Cambridge, MA: Harvard University Press, 1982), esp. p. 21. See also her "Mapping the Moral Domain: New Images of Self in Relationship," *Cross Currents* 39 (Spring 1989): 50–63.

[14] Gilligan and others deny that the two distinct voices correlate strictly with gender. See Gilligan and Susan Pollak, "The Vulnerable and Invulnerable Physician," in *Mapping the Moral Domain,* ed. C. Gilligan, J. Ward, and J. Taylor (Cambridge, MA: Harvard University Press, 1988), pp. 245–62.

[15] See Gilligan and G. Wiggins, "The Origins of Morality in Early Childhood Relationships," in *The Emergence of Morality in Young Children,* ed. J. Kagan and S. Lamm (Chicago: University of Chicago Press, 1988). See also Margaret Olivia Little, "Care: From Theory to Orientation and Back," *Journal of Medicine and Philosophy* 23 (1998): 190–209.

[16] Our formulations of these criticisms is influenced by Alisa L. Carse, "The 'Voice of Care': Implications for Bioethical Education," *Journal of Medicine and Philosophy* 16 (1991): 5–28, esp. 8–17. For assessment of such criticisms, see Abraham Rudnick, "A Meta-Ethical Critique of Care Ethics," *Theoretical Medicine* 22 (2001): 505–17.

[17] Alisa L. Carse, "Impartial Principle and Moral Context: Securing a Place for the Particular in Ethical Theory," *Journal of Medicine and Philosophy* 23 (1998): 153–69.

[18] See See Christine Grady and Anthony S. Fauci, "The Role of the Virtuous Investigator in Protecting Human Research Subjects," *Perspectives in Biology and Medicine* 59 (2016): 122-131; Nel Noddings, *Caring: A Feminine Approach to Ethics and Moral Education,* 2nd ed. (Berkeley, CA: University of California Press, 2003), and the evaluation of Noddings' work in Halwani, "Care Ethics and Virtue Ethics," esp. pp. 162ff.

[19] See Nancy Sherman, *The Fabric of Character* (Oxford: Oxford University Press, 1989), pp. 13–55; and Martha Nussbaum, *Love's Knowledge* (Oxford: Oxford University Press, 1990). On "attention" in medical care, see Margaret E. Mohrmann, *Attending Children: A Doctor's Education* (Washington, DC: Georgetown University Press, 2005).

[20] Carse, "The 'Voice of Care,'" p. 17.

[21] Other virtues are similarly important. We treat several later in this chapter and in Chapter 9. On the historical role of a somewhat different collection of central virtues in medical ethics and their connection to vices, especially since the eighteenth century, see Frank A. Chervenak and Laurence B. McCullough, "The Moral Foundation of Medical Leadership: The Professional Virtues of the Physician as Fiduciary of the Patient," *American Journal of Obstetrics and Gynecology* 184 (2001): 875–80.

[22] Edmund D. Pellegrino, "Toward a Virtue-Based Normative Ethics," p. 269. Compassion is often regarded as one of the major marks of an exemplary health care professional. See Helen Meldrum, *Characteristics of Compassion: Portraits of Exemplary Physicians* (Sudbury, MA; Jones and Bartlett, 2010).

[23] See Lawrence Blum, "Compassion," in *Explaining Emotions,* ed. Amélie Oksenberg Rorty (Berkeley, CA: University of California Press, 1980); and David Hume, *A Dissertation on the Passions,* ed. Tom L. Beauchamp (Oxford: Clarendon Press, 2007), Sect. 3, §§ 4–5.

[24] Martha Nussbaum, *Upheavals of Thought: The Intelligence of Emotions* (Cambridge: Cambridge University Press, 2001), p. 302. Part II of this book is devoted to compassion.

[25] See Jodi Halpern, *From Detached Concern to Empathy: Humanizing Medical Practice* (New York: Oxford University Press, 2001). For a variety of largely positive essays on empathy, see Howard Spiro, et al., eds., *Empathy and the Practice of Medicine* (New Haven, CT: Yale University Press, 1993); and Ellen Singer More and Maureen A. Milligan, eds., *The Empathic Practitioner: Empathy, Gender, and Medicine* (New Brunswick, NJ: Rutgers University Press, 1994). A valuable set of philosophical and psychological perspectives on empathy appears in Amy Coplan and Peter Goldie, eds., *Empathy: Philosophical and Psychological Perspectives* (Oxford: Oxford University Press, 2011). Jean Decety, ed., *Empathy: From Bench to Bedside* (Cambridge: MIT Press, 2012) includes several essays in Part VI on "Empathy in Clinical Practice." For dangers of an overemphasis on empathy in medicine, see Jane Mcnaughton, "The Art of Medicine: The Dangerous Practice of Empathy," *The Lancet* 373(2009): 1940-1941. Paul Bloom offers a sustained psychological argument against empathy in favor of "rational compassion" in health care, and many other areas, in his *Against Empathy: The Case for Rational Compassion* (New York: Ecco Press of HarperCollins, 2016). Some commentators on his thesis recognize the legitimacy of his concerns, for instance, about empathy in health care, but call for a more nuanced perspective and greater appreciation of the value of empathy. See the discussion in response to his essay entitled "Against Empathy" in a Forum in the *Boston Review*, September 10, 2014, available at http://bostonreview.net/forum/paul-bloom-against-empathy (accessed July 22, 2018). Much in this debate hinges on different interpretations of the concept, criteria, and descriptions of empathy.

[26] David Hume, *A Treatise of Human Nature,* ed. David Fate Norton and Mary Norton

(Oxford: Clarendon Press, 2007), 3.3.1.7.

[27] Baruch Brody, "Case No. 25. 'Who Is the Patient, Anyway': The Difficulties of Compassion," in *Life and Death Decision Making* (New York: Oxford University Press, 1988), pp. 185–88.

[28] Aristotle, *Nicomachean Ethics,* trans. Terence Irwin, second edition (Indianapolis: Hackett, 2000), $1106^{b}15$–29, $1141^{a}15$–$1144^{b}17$.

[29] Annette Baier, "Trust, Suffering, and the Aesculapian Virtues," in *Working Virtue: Virtue Ethics and Contemporary Moral Problems,* ed. Rebecca L. Walker and Philip J. Ivanhoe (Oxford: Clarendon, 2007), p. 137.

[30] See Annette Baier's "Trust and Antitrust" and two later essays on trust in her *Moral Prejudices* (Cambridge, MA: Harvard University Press, 1994); Nancy N. Potter, *How Can I Be Trusted: A Virtue Theory of Trustworthiness* (Lanham, MD: Rowman & Littlefield, 2002); Philip Pettit, "The Cunning of Trust," *Philosophy & Public Affairs* 24 (1995): 202–25; and Pellegrino and Thomasma, *The Virtues in Medical Practice,* chap. 5.

[31] Aristotle, *Eudemian Ethics,* $1242^{b}23$–$1243^{a}13$, in *The Complete Works of Aristotle,* ed. Jonathan Barnes (Princeton, NJ: Princeton University Press, 1984).

[32] For discussions of the erosion of trust in medicine, see Robert J. Blendon, John M. Benson, and Joachim O. Hero, "Public Trust in Physicians—U.S. Medicine in International Perspective" (a project studying 29 industrialized countries sponsored by the Robert Wood Johnson Foundation), *New England Journal of Medicine* 371 (2014): 1570-1572; David A. Axelrod and Susan Dorr Goold, "Maintaining Trust in the Surgeon-Patient Relationship: Challenges for the New Millennium," *JAMA Surgery* (Archives Surgery) 135 (January 2000), available at https://jamanetwork.com/journals/jamasurgery/fullarticle/390488 (accessed March 17, 2018); David Mechanic, "Public Trust and Initiatives for New Health Care Partnerships," *Milbank Quarterly* 76 (1998): 281–302; Pellegrino and Thomasma in *The Virtues in Medical Practice,* pp. 71–77; and Mark A. Hall, "The Ethics and Empirics of Trust," in *The Ethics of Managed Care: Professional Integrity and Patient Rights,* ed. W. B. Bondeson and J. W. Jones (Dordrecht, Netherlands: Kluwer, 2002), pp. 109–26. Broader explorations of trustworthiness, trust, and distrust appear in Russell Hardin's *Trust and Trustworthiness,* The Russell Sage Foundation Series on Trust, vol. 4 (New York: Russell Sage Foundation Publications, 2004). See further Onora O'Neill's proposals to restore trust in medical and other contexts where mistrust results from factors such as bureaucratic structures of accountability, excessive transparency, and public culture: *A Question of Trust* (Cambridge: Cambridge University Press, 2002) and *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2003).

[33] Brody, *Life and Death Decision Making,* p. 35. On the interpretation of integrity as a virtue, see Damian Cox, Marguerite La Caze, and Michael Levine, "Integrity," *The Stanford*

Encyclopedia of Philosophy (Spring 2017 Edition), ed. Edward N. Zalta, available at https://plato.stanford.edu/archives/spr2017/entries/integrity/ (accessed March 27, 2018).

[34] On the connection of, and the distinction between, autonomy and integrity, see Carolyn McLeod, "How to Distinguish Autonomy from Integrity," *Canadian Journal of Philosophy* 35 (2005): 107–133.

[35] On integrity as a virtue in the medical professions, see Edmund D. Pellegrino, "Codes, Virtue, and Professionalism," in *Methods of Medical Ethics,* ed. Jeremy Sugarman and Daniel P. Sulmasy, revised 2nd edition (Washington, DC: Georgetown University Press, 2010), pp. 91–107, esp. 94; and Michael Wreen, "Medical Futility and Physician Discretion," *Journal of Medical Ethics* 30 (2004): 275–78.

[36] For useful discussions of this question in nursing, see Martin Benjamin and Joy Curtis, *Ethics in Nursing: Cases, Principles, and Reasoning,* 4th ed. (New York: Oxford University Press, 2010), pp. 122–26; and Betty J. Winslow and Gerald Winslow, "Integrity and Compromise in Nursing Ethics," *Journal of Medicine and Philosophy* 16 (1991): 307–23. A wide-ranging discussion is found in Martin Benjamin, *Splitting the Difference: Compromise and Integrity in Ethics and Politics* (Lawrence, KS: University Press of Kansas, 1990).

[37] For a historically grounded critique of such conceptions and a defense of conscience as a virtue, see Douglas C. Langston, *Conscience and Other Virtues: From Bonaventure to MacIntyre* (University Park, PA: Pennsylvania State University Press, 2001). For another historical perspective, see Richard Sorabji, *Moral Conscience Through the Ages: Fifth Century BCE to the Present* (Chicago: University of Chicago Press, 2014).

[38] Bernard Williams, "A Critique of Utilitarianism," in J. J. C. Smart and Williams, *Utilitarianism: For and Against* (Cambridge: Cambridge University Press, 1973), pp. 97–98.

[39] We here draw from two sources: Hannah Arendt, *Crises of the Republic* (New York: Harcourt, Brace, Jovanovich, 1972), p. 62; and John Stuart Mill, *Utilitarianism,* chap. 3, pp. 228–29, and *On Liberty,* chap. 3, p. 263, in *Collected Works of John Stuart Mill,* vols. 10, 18 (Toronto, Canada: University of Toronto Press, 1969, 1977).

[40] Carl H. Fellner, "Organ Donation: For Whose Sake?" *Annals of Internal Medicine* 79 (October 1973): 591.

[41] Carson Strong, "Specified Principlism," *Journal of Medicine and Philosophy* 25 (2000): 285–307; John H. Evans, "A Sociological Account of the Growth of Principlism," *Hastings Center Report* 30 (September–October 2000): 31–38; Evans, *Playing God: Human Genetic Engineering and the Rationalization of Public Bioethical Debate* (Chicago: University of Chicago Press, 2002); and Evans, *The History and Future of Bioethics: A Sociological View* (New York: Oxford University Press, 2011). For a critical analysis of Evans' arguments,

particularly in *Playing God*, see James F. Childress, "Comments," *Journal of the Society of Christian Ethics* 24, no. 1 (2004): 195-204. See also Daniel P. Sulmasy, "What Is Conscience and Why Is Respect for It So Important?" *Theoretical Medicine and Bioethics* 29 (2008): 135–149; Damian Cox, Marguerite La Caze, and Michael Levine, "Integrity," *The Stanford Encyclopedia of Philosophy* (Spring 2017 Edition), ed. Edward N. Zalta, available at https://plato.stanford.edu/archives/spr2017/entries/integrity/ (accessed February 25, 2018); Larry May, "On Conscience," *American Philosophical Quarterly* 20 (1983): 57–67; C. D. Broad, "Conscience and Conscientious Action," in *Moral Concepts,* ed. Joel Feinberg (Oxford: Oxford University Press, 1970), pp. 74–79; James F. Childress, "Appeals to Conscience," *Ethics* 89 (1979): 315–35;.

[42] Douglas B. White and Baruch Brody, "Would Accommodating Some Conscientious Objections by Physicians Promote Quality in Medical Care?" *JAMA* 305 (May 4, 2011): 1804-1805.

[43] For several models, see Rebecca Dresser, "Professionals, Conformity, and Conscience," *Hastings Center Report* 35 (November–December 2005): 9–10; Mark R. Wicclair, *Conscientious Objection in Health Care: An Ethical Analysis* (Cambridge: Cambridge University Press, 2011); Alta R. Charo, "The Celestial Fire of Conscience—Refusing to Deliver Medical Care," *New England Journal of Medicine* 352 (2005): 2471–73; and Elizabeth Fenton and Loren Lomasky, "Dispensing with Liberty: Conscientious Refusal and the 'Morning-After Pill,'" *Journal of Medicine and Philosophy* 30 (2005): 579–92.

[44] See Holly Fernandez Lynch, *Conflicts of Conscience: An Institutional Compromise* (Cambridge, MA: MIT Press, 2008).

[45] The rest of the physicians are opposed or undecided. Farr A. Curlin et al., "Religion, Conscience, and Controversial Clinical Practices," *New England Journal of Medicine* 356 (February 8, 2007): 593–600.

[46] Dan W. Brock offers a similar framework for ethical analysis in what he calls the "conventional compromise" in "Conscientious Refusal by Physicians and Pharmacists: Who is Obligated to Do What, and Why?" *Theoretical Medicine and Bioethics* 29 (2008): 187-200. For the legal framework in the U.S., see Elizabeth Sepper, "Conscientious Refusals of Care," in *The Oxford Handbook of U.S. Health Law*, ed. I. Glenn Cohen, Allison Hoffman, and William M. Sage (New York: Oxford University Press, 2017), Chapter 16.

[47] Our analysis is indebted to David Heyd, *Supererogation: Its Status in Ethical Theory* (Cambridge: Cambridge University Press, 1982); Heyd, "Tact: Sense, Sensitivity, and Virtue," *Inquiry* 38 (1995): 217–31; Heyd, "Obligation and Supererogation," *Encyclopedia of Bioethics,* 3rd ed. (New York: Thomson Gale, 2004), vol. 4, pp. 1915–20; and Heyd, "Supererogation," *The Stanford Encyclopedia of Philosophy* (Spring 2016 Edition), ed. Edward N. Zalta, available

at https://plato.stanford.edu/archives/spr2016/entries/supererogation (accessed March 27, 2018). We are also indebted to J. O. Urmson, "Saints and Heroes," *Essays in Moral Philosophy,* ed. A. I. Melden (Seattle, WA: University of Washington Press, 1958), pp. 198–216; John Rawls, *A Theory of Justice* (Cambridge, MA: Harvard University Press, 1971; rev. ed. 1999), pp. 116–17, 438–39, 479–85 (1999: 100–01, 385–86, 420–25); Joel Feinberg, "Supererogation and Rules," *Ethics* 71 (1961); and Gregory Mellema, *Beyond the Call of Duty: Supererogation, Obligation, and Offence* (Albany, NY: State University of New York Press, 1991). For central connections between virtue and supererogation, see Roger Crisp, "Supererogation and Virtue," in *Oxford Studies in Normative Ethics* (vol. 3), ed. Mark Timmons (Oxford and New York: Oxford University Press, 2013), article 1.

[48] Albert Camus, *The Plague,* trans. Stuart Gilbert (New York: Knopf, 1988), p. 278.

[49] The formulation in this sentence relies in part on Rawls, *A Theory of Justice,* p. 117 (1999 edition, p. 100).

[50] Feinberg, "Supererogation and Rules," 397.

[51] See Dena Hsin-Chen and Darryl Macer, "Heroes of SARS: Professional Roles and Ethics of Health Care Workers," *Journal of Infection* 49 (2004): 210–15; Joseph J. Fins, "Distinguishing Professionalism and Heroism When Disaster Strikes: Reflections on 9/11, Ebola, and Other Emergencies," *Cambridge Quarterly of Healthcare Ethics* 24 (October 2015): 373-84; Angus Dawson, "Professional, Civic, and Personal Obligations in Public Health Emergency Planning and Response," in *Emergency Ethics: Public Health Preparedness and Response*, ed. Bruce Jennings, John D. Arras, Drue H. Barrett, and Barbara A. Ellis (New York: Oxford University Press, 2016), pp. 186-219. Early discussions of HIV/AIDS, when there were major concerns about transmission in the clinical setting, frequently addressed the clinician's responsibility to treat. Examples include Bernard Lo, "Obligations to Care for Persons with Human Immunodeficiency Virus," *Issues in Law & Medicine* 4 (1988): 367–81; Doran Smolkin, "HIV Infection, Risk Taking, and the Duty to Treat," *Journal of Medicine and Philosophy* 22 (1997): 55–74; and John Arras, "The Fragile Web of Responsibility: AIDS and the Duty to Treat," *Hastings Center Report* 18 (April–May 1988): S10–20.

[52] American Medical Association (AMA), *Code of Medical Ethics of the American Medical Association*, adopted May 1847 (Philadelphia: T.K. and P.G. Collins, 1848), available at http://ethics.iit.edu/ecodes/sites/default/files/Americaan%20Medical%20Association%20Code%20of%20Medical%20Ethics%20%281847%29.pdf (accessed March 17, 2018).

[53] See American Medical Association, Council on Ethical and Judicial Affairs, "Ethical Issues Involved in the Growing AIDS Crisis," *Journal of the American Medical Association* 259 (March 4, 1988): 1360–61.

[54] Health and Public Policy Committee, American College of Physicians and Infectious Diseases Society of America, "The Acquired Immunodeficiency Syndrome (AIDS) and Infection with the Human Immunodeficiency Virus (HIV)," *Annals of Internal Medicine* 108 (1988): 460–61. See further Edmund D. Pellegrino, "Character, Virtue, and Self-Interest in the Ethics of the Professions," *Journal of Contemporary Health Law and Policy* 5 (1989): 53–73, esp. 70–71.

[55] Aristotle, *Nicomachean Ethics,* trans. Irwin, 1101^{a}1–7.

[56] Rawls, *A Theory of Justice,* pp. 443–45 (1999 edition: 389–91). On the Aristotelian principle, see pp. 424–33 (1999 edition: 372–80).

[57] Urmson recognized this problem in "Saints and Heroes," pp. 206, 214. Imbalance is found in forms of utilitarianism that make strong demands of obligation. However, see the attempt to revise consequentialism to bring it in line with common moral intuitions in Douglas W. Portman, "Position-Relative Consequentialism, Agent-Centered Options, and Supererogation," *Ethics* 113 (2003): 303–32.

[58] A reasonable skepticism is evident in some influential philosophical works such as those of Susan Wolf (in the article cited below), Philippa Foot, Bernard Williams, and Thomas Nagel.

[59] Aristotle, *Nicomachean Ethics,* trans. Irwin, 1103^{a}32–1103^{b}1.

[60] Edith Wyschogrod offers a definition of a "saintly life" as "one in which compassion for the other, irrespective of cost to the saint, is the primary trait." Wyschogrod, *Saints and Postmodernism: Revisioning Moral Philosophy* (Chicago: University of Chicago Press, 1990), pp. xiii, xxii, et passim.

[61] John Berger (and Jean Mohr, photographer), *A Fortunate Man: The Story of a Country Doctor* (London: Allen Lane, the Penguin Press, 1967), esp. pp. 48, 74, 82ff, 93ff, 123–25, 135. Lawrence Blum pointed us to this book and influenced our perspective on it. Sassall's wife played a critical role in running his medical practice and helping him deal with his manic-depressive illness; she receives little attention in the book, which is, however, dedicated to her. She died in 1981, and he committed suicide the next year. See Roger Jones, "Review: *A Fortunate Man*," *British Journal of General Practice,* February 9, 2015, available at http://bjgplife.com/2015/02/09/review-a-fortunate-man/ (accessed July 20, 2018). See also Gavin Francis, "John Berger's *A Fortunate Man*: A Masterpiece of Witness," *The Guardian*, February 7, 2015, available at https://www.theguardian.com/books/2015/feb/07/john-sassall-country-doctor-a-fortunate-man-john-berger-jean-mohr (accessed, July 20, 2018).

[62] Our conditions of moral excellence are indebted to Lawrence Blum, "Moral Exemplars," *Midwest Studies in Philosophy* 13 (1988): 204. See also Blum's "Community and

Virtue," in *How Should One Live?: Essays on the Virtues,* ed. Crisp.

[63] Our second and third conditions are influenced by the characterization of a saint in Susan Wolf's "Moral Saints," *Journal of Philosophy* 79 (1982): 419–39. For a pertinent critique of Wolf's interpretation, see Robert Merrihew Adams, "Saints," *Journal of Philosophy* 81 (1984), reprinted in Adams, *The Virtue of Faith and Other Essays in Philosophical Theology* (New York: Oxford University Press, 1987), pp. 164–73.

[64] For an examination of some 21st-century figures who lived under extreme conditions with exceptional moral commitment, see Larissa MacFarquhar, *Strangers Drowning: Impossible Idealism, Drastic Choices, and the Urge to Help* (New York: Penguin Books, 2016).

[65] Jay Katz, ed., *Experimentation with Human Beings* (New York: Russell Sage Foundation, 1972), pp. 136–40; Lawrence K. Altman, *Who Goes First?: The Story of Self-Experimentation in Medicine,* 2nd edition, with a new preface (Berkeley, CA: University of California Press, 1998), pp. 1-5, 39-50, et passim.

[66] Philip J. Hilts, "French Doctor Testing AIDS Vaccine on Self," *Washington Post,* March 10, 1987, p. A7; Altman, *Who Goes First?,* pp. 26-28.

[67] We will not consider whether these conditions point to a still higher form of moral excellence: the combination of saint and hero in one person. There have been such extraordinary persons, and we could make a case that some of these extraordinary figures are more excellent than others. But at this level of moral exemplariness, such fine distinctions serve no purpose.

[68] These cases can be read as suggesting that many people who are commonly called heroes or saints are not very different from good and decent but morally ordinary people. This theory is not explored here (except implicitly in our account of the continuum from ordinary morality to supererogation), but it is examined in Andrew Michael Flescher, *Heroes, Saints, and Ordinary Morality* (Washington: Georgetown University Press, 2003). Flescher provides historical examples of people commonly regarded as saints or heroes.

[69] David Hilfiker, *Not All of Us Are Saints: A Doctor's Journey with the Poor* (New York: Hill & Wang, 1994). The summaries and quotations that follow come from this book. His earlier book, *Healing the Wounds: A Physician Looks at His Work* (New York: Pantheon, 1985) focuses on his previous experiences as a family physician in rural Minnesota. The personal problems he (and some others we discuss) faced underline a critical point in this chapter: Difficulties that can arise in balancing a commitment to a moral ideal or moral excellence with personal needs.

[70] Arthur Kleinman, *What Really Matters: Living a Moral Life Amidst*

Uncertainty and Danger (New York: Oxford University Press, 2006), chap. 3. The quotations are from this work.

[71] For the attitudes of nephrologists, transplant nephrologists, transplant surgeons, and the like, see Carol L. Beasley, Alan R. Hull, and J. Thomas Rosenthal, "Living Kidney Donation: A Survey of Professional Attitudes and Practices," *American Journal of Kidney Diseases* 30 (October 1997): 549–57; and Reginald Y. Gohh, Paul E. Morrissey, Peter N. Madras, et al., "Controversies in Organ Donation: The Altruistic Living Donor," *Nephrology Dialysis Transplantation* 16 (2001): 619-21, available at https://academic.oup.com/ndt/article/16/3/619/1823109 (accessed Feb. 26, 2018). Even though strong support now exists for living kidney donation, actual medical practice is not uniformly in agreement.

[72] See Aaron Spital and Max Spital, "Living Kidney Donation: Attitudes Outside the Transplant Center," *Archives of Internal Medicine* 148 (May 1988): 1077–80; Aaron Spital, "Public Attitudes toward Kidney Donation by Friends and Altruistic Strangers in the United States," *Transplantation* 71 (2001): 1061-64.

[73] From 1996 to 2005, as living kidney donation overall doubled in the United States, the annual percentage of genetically unrelated kidney donors (excluding spouses) rose from 5.9% to 22%. *2006 Annual Report of the U.S. Organ Procurement and Transplantation Network and the Scientific Registry of Transplant Recipients: Transplant Data 1996–2005* (Rockville, MD: Health Resources and Services Administration, Healthcare Systems Bureau, Division of Transplantation, 2006). During the years 2001–03, acts of living organ donation outnumbered acts of deceased organ donation, but living organ donation, which had increased for the preceding five years, declined steadily after 2004 for both kidneys and livers. See A. S. Klein, E. E. Messersmith, L. E. Ratner, et al., "Organ Donation and Utilization in the United States, 1999–2008," *American Journal of Transplantation* 10 (Part 2) (2010): 973–86. This slide has continued. See James R. Rodrigue, Jesse D. Schold, and Didier A. Mandelbrot, "The Decline in Living Kidney Donation in the United States: Random Variation or Cause for Concern?" *Transplantation Journal* 96 (2013): 767-773.

[74] Evelyn Nieves, "Girl Awaits Father's 2nd Kidney, and Decision by Medical Ethicists," *New York Times,* December 5, 1999, pp. A1, A11.

[75] See Linda Wright, Karen Faith, Robert Richardson, and David Grant, "Ethical Guidelines for the Evaluation of Living Organ Donors," *Canadian Journal of Surgery* 47 (December 2004): 408–12. See also A. Tong, J. R. Chapman, G. Wong, et al., "Living Kidney Donor Assessment: Challenges, Uncertainties and Controversies Among Transplant Nephrologists and Surgeons," *American Journal of Transplantation* 13 (2013): 2912-23. For further examination of ethical issues in living organ donation, see James F. Childress and Cathryn T. Liverman, eds., *Organ Donation: Opportunities for Action* (Washington, DC: National Academies Press, 2006), chap. 9.

[76] A vigorous debate continues about whether it would be ethically acceptable to add financial incentives for living organ donation, beyond removing financial disincentives. Such incentives would change some donors' motivations for donation, which already may include factors in addition to their altruism. </N>