would be detrimental to the patient. (This dilemma is discussed in Chapter 3.) Thinking in terms of Ross's theory, we can structure the dilemma as follows. The prima facie duty to follow a physician's orders comes into conflict with two other prima facie duties. First, there is a relevant duty of nonmaleficence. A nurse should not act in a way that would, in effect, injure another person. Second, there is another relevant duty of fidelity, deriving from the fact that a nurse has an implicit contract or agreement with the patient to act in his or her best medical interest. Is the collective force of these two prima facie duties more incumbent upon the nurse than the prima facie duty to follow a physician's orders? Since the duty of nonmaleficence is recognized by Ross (and "ordinary moral consciousness") as especially stringent, it seems that, in most cases, at least where the potential harm to patients is significant, the nurse must conclude that it would be wrong to follow the physician's order.

Abstracting from any relevant role responsibilities on the part of health-care professionals, the issue of the moral justifiability of active euthanasia (discussed in Chapter 6) might be conceptualized, in accordance with Ross's scheme, as a moral dilemma involving the conflict between a duty of beneficence and a duty of nonmaleficence. A terminally ill person suffering unbearable pain could be understood to benefit from an immediate and painless death. Thus, we have on one hand a duty of beneficence—the prima facie duty to come to the assistance of a person in serious distress—and on the other hand a duty of nonmaleficence—the prima facie duty not to kill.

Critical Assessment of Ross's Theory Since Ross developed his theory of prima facie duties explicitly in reference to the promptings of "ordinary moral consciousness," it would be surprising if his theory could not be reconciled with our experience of the moral life. Indeed, let us put aside whatever worries might be expressed on this score, for there is a much more obvious deficiency in Ross's theory. Recall that we have asked not only that an ethical theory be largely reconcilable with our experience of the moral life but also that it provide us with effective guidance where it is most needed, in the face of moral dilemmas. And despite the fact that Ross's theory provides us with a helpful framework for conceptualizing our moral dilemmas, it provides us with virtually no substantive guidance for resolving them.

In the difficult cases, where two prima facie duties come into strong conflict, Ross holds that there are no principles we can appeal to in an effort to make an appropriate decision. The most we can do, in his view, is render a "considered decision" as to which duty is more incumbent upon us in a certain situation. Although it is fine to be told to make a considered decision, what exactly is worthy of consideration in reaching a decision? At this point, there is a strong argument for moving beyond Ross's theory. One plausible approach would identify *considerations of coherence* (within our overall system of moral convictions) as the relevant standard. (See the discussion "Reflective Equilibrium and Appeals to Coherence" later in this chapter.) If Ross's theory were supplemented with a coherence-based decision procedure, the advantages of thinking in terms of prima facie duties could be combined with a plausible methodology for mediating among conflicting duties.

THE PRINCIPLES OF BIOMEDICAL ETHICS

One prominent approach to problems in biomedical ethics has been articulated by Tom Beauchamp and James Childress in *Principles of Biomedical Ethics*, originally published in 1979. The basic idea is that problems can be appropriately identified, analyzed, and resolved by reference to a set of four principles, each of which corresponds to a prima facie (i.e., conditional) obligation. The four principles, tailored specifically to be relevant in the field of biomedical ethics, are as follows: the principle of respect for autonomy, the principle of nonmaleficence, the principle of beneficence, and the principle of justice.

This distinctive principle-based approach has much in common with W. D. Ross's theory of prima facie duties, which can also be understood as a principle-based approach. In each case, we are dealing with several prima facie principles of obligation. So in each case, it is common for the principles of the system to conflict, thus requiring a judgment as to which principle has overriding weight or significance in any particular set of circumstances.[19]

Frequent references to "the principles of biomedical ethics," both individually and collectively, can be found in the literature of biomedical ethics (including the readings collected in this textbook). As presented by Beauchamp and Childress, each of the principles must ultimately be understood by reference to numerous distinctions and clarifications. For our purposes, however, it is useful to identify a central (if less than complete) meaning for each principle. The *principle of respect for autonomy* requires that health-care professionals not interfere with the effective exercise of patient autonomy. (A suggested analysis of the concept of autonomy is presented in a later section of this chapter.) The *principle of nonmaleficence* requires that health-care professionals not act in ways that entail harm or injury to patients. The *principle of beneficence* requires that health-care professionals act in ways that promote patient welfare. (The closely related concepts of beneficence and nonmaleficence are briefly explicated in our earlier discussion of Kantian deontology.) The *principle of justice* requires that social benefits (e.g., health-care services) and social burdens (e.g., taxes) be distributed in accordance with the demands of justice. Although this articulation of the principle of justice is somewhat uninformative, it is impossible to give the principle any clearer content without considering questions that are at issue in competing theories of distributive justice. These theories are discussed in the introduction to Chapter 9.

ALTERNATIVE DIRECTIONS AND METHODS

By the 1990s a challenge was well underway both to recently dominant ethical theories (that is, those theories—discussed earlier—that commanded the most attention in the twentieth century) and to the idea that these theories can simply be *applied* to generate satisfactory solutions to concrete problems. In biomedical ethics, criticisms have increasingly been directed at two broad approaches to ethical reasoning. These approaches are known as *deductivism* and *principle-based ethics* (also called "principlism"). A deductivist theory, such as utilitarianism or Kantianism, features a single foundational principle that supposedly provides a basis for all ethical justification.[20] According to this approach, correct ethical judgments can, in principle, be derived from the foundation, given relevant factual information (e.g., concerning the consequences of possible actions, in utilitarianism). As we saw in the previous section, principle-based ethics features a framework of several principles, rules, or duties, none of which takes absolute priority over any other. In principle-based ethics, as it is commonly understood,[21] one considers whatever principles, rules, or duties are relevant in the circumstances, settling conflicts by determining which seems more weighty.[22] Specific criticisms of deductivism and principle-based ethics will emerge in the discussions of leading alternative approaches.

VIRTUE ETHICS

An emphasis on the moral evaluation of *actions* is common both to deductivist theories and to principle-based ethics. These approaches offer principles or rules of conduct as their main source of moral guidance. One is directed to maximize utility, never to treat persons as mere means to one's ends, or the like. Sometimes principles or rules are expressed in the language of rights and duties. For example, it is said that competent adults have a right to refuse medical treatment and health-care professionals have a duty to respect the decision making of competent adults. In contrast, virtue ethics, the tradition of Plato and Aristotle, gives *virtuous character* a preeminent place. For our purposes, virtues may be understood as character traits that are morally valued, such as truthfulness, courage, compassion, and sincerity. In virtue ethics, agents—those performing the actions—are the focus. Whereas the principal concern in an action-based approach to ethics is with the right thing to do, the principal concern in a virtue-based approach is with what kind of person to be.

In recent years there has been a significant revival of virtue ethics, a development affecting bioethics. Some theorists have argued that mainstream theories have overemphasized action-guides to the neglect of issues of character. What is needed, they maintain, is a *supplementation* of action-based ethics with virtue ethics. Other theorists have defended the more radical thesis that the neglect of virtue has caused action-based ethical theories to be *importantly misconceived* (so that merely supplementing them is insufficient). Among these theorists, some have argued for a robust *integration* of action-based ethics and virtue ethics (without giving priority to either), while others have gone further, calling for the *replacement* of action-based ethics by virtue ethics.

What arguments can be advanced in favor of virtue ethics? One difficulty with theories that are solely action-based is that they seem to neglect the fact that we often morally judge people's motivations and character, not just their actions. For example, in praising someone's kindness or criticizing a person's meanness, our evaluation makes no explicit reference to actions. Sometimes we even fault a person who acts rightly but with questionable motivation or attitude. For example, consider a person who gives to charities only when seeking public office, or a surgeon who only begrudgingly solicits a patient's informed consent to surgery. Conversely, sometimes we temper our blame of a person who has acted wrongly if, in doing so, admirable motives and character traits were displayed. For example, we might moderate our criticism of someone who lied to assuage another's feelings, even if we think lying was the wrong choice.

Another argument addresses what is most useful in guiding moral choice. It is claimed that principles, rules, and codes are of little use in actual decision making (e.g., in biomedical contexts). Such action-guides are too abstract to provide practical guidance. Moreover, they often conflict. (The suggestion that conflicts can be effectively resolved by appeal to an ethical theory immediately confronts the problem that there is such extensive disagreement on which theory is most adequate.) A more effective approach, according to this argument, is to cultivate enduring traits (such as competence, attentiveness, honesty, compassion, and loyalty) through education, the influence of role models, and habitual exercise of those traits. Such virtues, it is claimed, are a more reliable basis, in practice, for morally correct action than is knowledge of principles, rules, or codes.

The arguments surveyed so far are compatible with the program of supplementing action-based theories with virtue ethics. Even the idea that virtues are more useful in practice is consistent with these claims: (1) Ethics is more centrally concerned with what people should do (virtues being generally reliable means for doing the right thing); (2) right action, in principle, can be characterized without reference to virtue. However, the following arguments are more radical. They suggest that virtue is often at least as morally important or fundamental as right action and that sometimes the latter cannot even be characterized independently of virtue.

First, several philosophers have argued that in many cases right action cannot be described in an illuminating way without referring to virtue. Consider the idea that we should help those who are suffering. (This idea expresses a principle of action.) Truly helping someone often requires keen attention to the subtleties of the situation at hand to determine whether, and what sort of, intervention is called for. Would calling a particular student aside, telling him or her an anecdote, and offering advice be helpful, or would it be intrusive and condescending? One cannot reliably perform acts that are helpful (as opposed to intrusive or condescending) without exercising a capacity for discernment, which involves such virtues as emotional attunement and sympathetic insightfulness.[23] Since being helpful in such circumstances involves being virtuous, the proper conclusion is that virtue partly constitutes right action.

Second, the manner in which we act—what we express in our action—can matter as much as, or more than, what we do. (We might even say that our manner of acting is part of what we do.) Suppose Earl borrows money from his brother, Jake, and promises to repay him within a month. Four weeks later Jake gently reminds Earl of his promise. If Earl later storms into his brother's house, slams down the money, and marches off in resentment and anger, he has fulfilled his duty to keep a promise, but he has not acted well. A full account of how Earl should have conducted himself would include a description of the manner in which he should have acted (perhaps courteously). Here, again, the conclusion is that virtue partly constitutes right action.

Moreover, sometimes emotional responses, which can reveal a person's character, are of paramount moral importance (a point suggested in the last example). This is especially evident in situations in which no particular action is morally called for. For example, a social worker might be deeply affected by another social worker's detailed account of a patient who lost his job and committed suicide. If the two work at different hospitals, there is probably nothing the first social worker can do about the tragedy. However, her pain at a stranger's plight reveals virtue; complete indifference arguably would reveal a moral deficiency.[24]

While the previous arguments probably succeed in showing the need to integrate virtue ethics and action-based ethics, there are compelling reasons to resist the stronger thesis that virtue ethics should *replace* action-based approaches. First, while action-guides such as principles and rules are not exhaustive of what is important in the moral life, neither is virtue. One can be well motivated and have a good character yet act wrongly; conversely, acting without virtue does not *always* mean doing the wrong thing. (This is consistent with the view that virtue sometimes partly constitutes right action.) Morally, we are concerned with both action and character, doing and being.

Second, the specificity of such action-guides as rules, codes, and rights-claims often provides an attractive form of bottom-line moral protection. Rules such as those requiring informed consent for medical interventions and prohibiting psychotherapists from having sexual relations with psychiatric patients provide an important bedrock of action requirements. In fact, such rules can often help professionals establish relationships with patients in which certain virtues can be exercised more naturally.

Similarly, it seems unlikely that any specification of virtues would be sufficient to guide conduct. In bioethics we are interested in such questions as "Is it ever right for a psychotherapist to violate patient confidentiality, and, if so, when?" Such a question probably cannot be answered by appeal to virtue alone. In conclusion, it would seem that an adequate portrait of the moral life would include action-guides such as principles, rules, and rights-claims—not just virtues. The question we are left with, then, is not whether both virtues and action-guides have important places in ethical theory and bioethics but, rather, how to understand in greater detail their roles and relationship to one another.

How might virtues play a role in biomedical ethics? Here is one example. A physician has just received test results strongly suggesting that her 30-year-old patient has inoperable ovarian cancer. Neither of them expected such a calamity. The physician knows that she has an obligation to inform her patient of the results. However, in reflecting on how to broach and discuss this matter with her, the physician finds such principles as beneficence and nonmaleficence too general to be useful; no helpful rules of conduct come to mind, either. The physician keeps coming back to such ideas as *compassion, sensitivity,* and *honesty.* Although these words describe virtues, we could say that "Be compassionate," "Be sensitive," and "Be honest" are rules of action. Nevertheless, such instructions do not really tell the physician how to handle her delicate predicament. To handle it well, she will have to *be* compassionate, sensitive, and honest, and no set of rules can explain how to be that way. The physician, in other words, will have to manifest virtue. She might find it useful to model her behavior on that of a mentor or colleague whom she identifies as having the desired qualities.

THE ETHICS OF CARE AND FEMINIST ETHICS

The ethics of care and feminist ethics represent further challenges to recently dominant ethical theories, to deductivism, and to principle-based ethics. While the ethics of care and feminist ethics both stem importantly from the moral experience of women, they represent overlapping—but certainly not identical—sets of concerns.

Like virtue ethics, the ethics of care pays considerable attention to affective components of the moral life, but with special emphasis on empathy and concern for the needs of others, that is, on caring. Like casuistry (an approach discussed in the next section), the ethics of care emphasizes the particularities and context of moral judgment. It also underscores the moral importance of relationships and the responsibilities to which they give rise.

Perhaps more than any other work, Carol Gilligan's study of gender differences in ethical thinking has brought the ethics of care into the mainstream of philosophical discussion.[25] In a study of responses to moral conflicts, Gilligan finds that females often focus on details about the relationships among the persons involved and to seek innovative solutions that protect everyone's interests. In contrast, males typically try to identify and apply a relevant principle or rule (which they take to be universal or valid from an impartial perspective), even if doing so means sacrificing someone's interests. Gilligan calls the former approach an *ethic of care* (or responsibility) and the latter (which includes recently dominant ethical theories) an *ethic of justice.* She notes in her study that the empirical correlations are far from perfect; males sometimes work from the care perspective and women fairly often use the justice approach. In any event, the tendencies she notes are striking, for they suggest that traditional approaches to ethics have been more responsive to the moral experience of males than to that of females. Gilligan concludes that there is no reason to consider the care perspective inferior and that an ideal ethics would incorporate both approaches.

As originally characterized by Gilligan and now generally understood, the ethics of care downplays rights and allegedly universal principles and rules in favor of an emphasis on caring, interpersonal relationships, and context. Numerous specific criticisms of recently dominant ethical theories have been developed in the ethics of care literature. A summary of several critical arguments follows.

To begin with, there is a problematic presumption underlying theories such as utilitarianism and Kantianism. The presumption is that impartiality is a fundamental aspect of moral thinking. In reality, impartiality is a demand reflective of male thinking; the partiality that comes with caring relationships is no less legitimate. Indeed, certain relationships merit special weight. For example, in many contexts, a father should favor his own children's interests over those of other children. Moreover, the abstract principles of traditional theories have very limited practical use; contextualization and attention to detail are needed for problem solving in ethics. In many complex situations involving ethical conflicts, such principles as "Respect all persons as ends in themselves" and "Maximize utility" simply provide inadequate guidance.

Furthermore, ethical theories featuring abstract principles tend to neglect affective components of the moral life. Caring responsiveness to others' needs is often morally preferable to detached, dispassionate moral evaluation. For example, the ethics of care would strongly affirm a health-care professional's heartfelt dedication to a patient, without conditioning its value on good consequences or respect for persons. The abstract nature of recently dominant theories also tends to cover up certain morally salient experiences—such as being a woman, a parent, a minority, or a professional who has particular working relationships with other professionals.

A health-care professional working within the spirit of the ethics of care would bear in mind (or internalize) considerations such as these: (1) the individualized needs, both physical and psychological, of the patient; (2) how to respond in a caring, personalized manner to those needs; (3) the likely impact of various options on the quality of the relationships among the involved persons, including the patient and professional, but also other members of the health-care team and any involved family members; and (4) how to attain or maintain the best possible relationships among those persons. Suppose a nurse faces a conflict between loyalty to a patient and loyalty to the attending physician, who refuses to disclose certain medical options to the patient. The "justice" approach might view the dilemma in terms of overall utility, conflicting rights, or the like. In contrast, the ethics of care would emphasize the lived relationships and the responsibilities inherent in them, the impact of possible responses on those relationships, and the prospects for conflict resolution.

The relationship between *feminist ethics* and the ethics of care is a complex one, and this complexity is reflected in the different ways that various feminists have responded to the emergence and widespread discussion of the ethics of care. Some feminists have celebrated the reception accorded the ethics of care and feel validated by the recognition of a distinctly female moral perspective. Others, however, have reacted negatively to at least certain aspects of the ethics of care.

Feminist ethics can be initially characterized in the following ways. (1) As with the ethics of care, it is firmly committed to the view that the moral experience of women must be taken seriously (but often with a critical eye to the role that the subordination of women may play in shaping that experience). (2) It is deeply committed to the overriding moral importance of ending oppression—with special emphasis on the subordination of women.

These features of feminist ethics together motivate a redirection of focus to women (and, to an important extent, minorities and other historically disadvantaged groups). This

focus includes both an emphasis on the importance of women's interests and special attention to issues that especially concern or affect women. Thus, in bioethics, feminist ethics urges careful examination of the interests of women in matters of reproduction and as the almost exclusive participants in the profession of nursing. Special attention is also given, for example, to the distinctive needs of women in the area of medical research, to the moral complexities of surrogate motherhood, and to arguably sexist undercurrents in the promotion of in vitro fertilization and in various medical practices surrounding childbirth.

In feminist ethics, a critical eye is turned toward practices and institutions that may perpetuate and legitimate forms of oppression. Some of these practices and institutions, feminists argue, are so deeply embedded in our culture that they go unnoticed. Accordingly, some feminists have charged proponents of the ethics of care with naïveté for accepting women's moral experiences at face value—without questioning the oppressive practices and attitudes that may have helped make certain experiences and ways of thinking typical for women. Perhaps women's proficiency at caring is related to their subordinate status.[26] In fact, nurturing, caring, and the disposition to preserve relationships at almost any cost may simply be the survival skills of an oppressed group; it has been noted that such dispositions are also found among persons of both genders who are members of groups that have been subjected to slavery or colonization.[27] Some feminists also argue that the value of mothering, so affirmed in the ethics of care, may be tied to the norm of the nuclear family—a norm that can be seen as discounting the perspectives of homosexuals, persons in single-parent families, and others who remain legally unmarried. They point out that caring has led some women to direct nearly all of their energies to others' needs, without adequately attending to their own. While caring is an admirable trait in many circumstances, these feminists maintain, it is sometimes better withheld when a focus on rights and autonomy is necessary. In general, they conclude, we must not valorize the traits that tend to perpetuate women's subordinate status.[28]

How might we assess the ethics of care and feminist ethics as alternatives to recently dominant theories and to the idea that these theories can simply be applied in order to resolve concrete problems? The care perspective's emphasis on relationships and the affective components of the moral life merits careful attention; arguably, the traditional theories greatly understate their significance. (Ross's theory, which highlights morally significant relationships, is a partial exception.) The critical-minded attention of feminist ethics to oppression, inequalities, and issues pertaining to women and other disadvantaged groups is surely valuable. In addition, the feminist caution about gender stereotyping is well taken. Uncritical acceptance of traditionally feminine and masculine qualities may lead too easily to the assignment of people to "appropriate" roles (such as women to midnight infant feedings and men to aggressive professional pursuits).

However, the distance between the perspectives presently under discussion, on the one hand, and recently dominant theories, on the other, can easily be overdrawn. Utilitarians, for example, should be firmly dedicated to the eradication of oppression (given all of its bad consequences). Kantian respect for persons, while perhaps vague and abstract, is at least compatible with caring and special relationships (the validity of which could be impartially recognized). Caring attention to particularities might even provide a useful way of specifying or supplementing abstract but worthy principles.

In the end, Gilligan argues that "care" and "justice" are both only parts of a broader ethics, and few proponents of the care perspective propose that it monopolize ethics. In a pluralistic spirit, one might adopt a similar attitude toward feminist ethics, concentrating on

whatever insight and illumination this perspective brings to ethics. Following is a concluding suggestion from feminist philosopher Susan Sherwin:

> I do not envision feminist ethics to be a comprehensive . . . theory that can be expected to resolve every moral question with which it is confronted. It is a theoretical perspective that must be combined with other considerations to address the multitude of moral dilemmas that confront human beings. . . . Although very little of the literature in ethics addresses the issue of sexism or any other form of systematic oppression, surely the responsibility to do so in one's moral evaluations is implicit. Feminist ethics has assumed leadership in pursuing such analysis.[29]

CASUISTRY: CASE-BASED REASONING IN HISTORICAL CONTEXT

Casuistry, which has received a great deal of attention in recent years, is a method of moral reasoning that was reawakened from three centuries of slumber with the publication of *The Abuse of Casuistry,* by Albert Jonsen and Stephen Toulmin.[30] Following Aristotle and other philosophers as well as theologians throughout the ages, the authors contend that the "top-down" reasoning inherent in deductivism and principle-based ethics (as they understand it) is entirely inadequate for the resolution of concrete problems, such as those that arise in bioethics. (Jonsen and Toulmin never clearly distinguish deductivism and principle-based ethics. While some of their criticisms concern both approaches, others concern only deductivism.)

First, according to the casuists, no simple, unified ethical theory can capture the great diversity of our moral ideas, a consideration that helps to account for the fact that there is such extensive disagreement about ethical theories. Second, our actual moral thinking does not typically consist of straightforward deductive reasoning (deriving an ethical judgment from a supreme principle). *Practical wisdom* is required to determine which of various norms (principles or rules) applies in a complicated or ambiguous case. For example, if a patient awaiting admission to a fully occupied intensive care unit better fulfills admission criteria than someone already admitted, would it ever be right to admit the waiting patient if doing so would be detrimental to the one who would be displaced? Casuists doubt that the answers to such questions can be derived from a traditional ethical theory, such as utilitarianism or Kantianism, or from a set of abstract principles. Third, such approaches miss the fact that moral certainty, where it exists, concerns particular cases. For example, that a particular person acts wrongly in torturing for sadistic pleasure is far more certain than any full-blown ethical theory could be.

The alternative of casuistry is a form of case-based reasoning. It begins with clear "paradigm" cases in which some *maxim* (a relatively specific principle or rule) is clearly relevant and indicates the right action or judgment. For example, if we learn that a man stole a car just for a thrill, we know he acted wrongly. From this and similar cases we can extract a maxim, "Stealing is wrong," which holds in the absence of unusual circumstances. The paradigm cases illuminate other cases by way of analogy. Maxims are refined as new cases are confronted in which the norms apply ambiguously (for example, if someone finds an expensive watch in a classroom and does not attempt to locate its owner) or in conflict (for example, if someone believes that temporarily appropriating a bicycle is the only way to save an innocent person's life). Often, the refinements involve stating exceptions.

In order to reach a defensible moral judgment in any particular case, we must first determine which paradigms are relevant. Difficulties arise, of course, when paradigms fit only