# "Towards a strong practice-based virtue ethics for nursing"

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# ABSTRACT

Illness creates a range of negative emotions in patients including vulnerability, powerlessness and dependence on others for help. The nursing literature is saturated with debate about a 'therapeutic' nurse-patient relationship. However, despite the current agenda regarding patient-centred care, literature concerning the development of good interpersonal responses and the view that a satisfactory nursing ethics should focus on *persons* and *character traits* rather than *actions*, nursing ethics is dominated by the traditional obligation, act-centred theories such as consequentialism and deontology. I critically examine these theories and the role of duty-based notions in both general ethics and nursing practice. Because of well-established flaws, I conclude that obligation-based moral theories are incomplete and inadequate for nursing practice. Instead, the moral virtues and virtue ethics provide a plausible and viable alternative for nursing practice. I develop an account of a virtue-based helping relationship and a virtue-based approach to nursing. The latter is characterized by three features: (1) exercising the moral virtues such as compassion and courage, (2) using judgment and (3) using moral wisdom – moral perception, sensitivity and imagination. Merits and problems of this approach are examined. Following MacIntyre, I conceive nursing as a practice; nurses who exercise the virtues and seek the internal goods help to sustain the practice of nursing and thus prevent the marginalization of the virtues. The strong (action-guiding) practice based version of virtue ethics proposed is context-dependent, particularist and relational. Several areas for future philosophical inquiry and empirical nursing research are suggested to develop this account yet further.

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# FIGURE

# PREFACE

This thesis proposes a philosophical argument about the virtues and applies it to adult and mental health nursing. There are four stylistic issues to note.

First, I write this thesis in the first person as is customary in the arts including applied philosophy. Second, I use a modified form of the Vancouver referencing system. References and endnotes are compiled at the end of each chapter. I have attempted to keep endnotes to a minimum. In the 'Bibliography', there is an alphabetical list of literature that I have reviewed since March 2000. Third, in the chapters that focus on nursing, I have used the term 'patients' rather than 'clients'; I have done so because this is typical in philosophical ethics. And, fourth, for brevity I use 'nursing' to mean both adult and mental health nursing and I use 'nurses' to mean both adult and mental health nurses. If I need to make a distinction, then I make this clear.

# CHAPTER 1 – INTRODUCTION

## Introduction

In this Chapter, I set the scene for the argument to follow. I describe the aim of the thesis and provide some background information about my clinical experience. I describe my participation in 2 Delphi questionnaire studies and I explain the reasons behind this particular thesis. I clarify that this is a theoretical, not empirical, thesis. I close by outlining the content of each Chapter.

### Aim of the thesis

In this thesis, I argue that a strong virtue ethics and a virtue-based approach provide a defensible and plausible nursing ethics.

### Background to the thesis

I shall first describe my background both in terms of my nursing experience and interest in health care ethics. I then describe my involvement in two Delphi questionnaire studies. Finally, I consider my reasons for writing this thesis.

#### My background

I commenced my registered general nurse (RGN) training in June 1986 at the County Durham School of Nursing based in Darlington, County Durham, England. I enjoyed many aspects of the training, especially the clinical placements where one could see the reality of nursing practice.

The subject of ethics was not taught in my nurse-training program. I did not question this omission. Furthermore, I did not think that the development of the nurse-patient relationship involved a moral dimension.

I became fascinated and perplexed by the wide range of moral dilemmas, problems and issues in nursing practice. With hindsight, my conceptual framework was a combination of patients' rights and nurses' obligations. I also began to critically reflect about a broad range of nursing issues.

My interest in nursing ethics and critical reasoning intensified when I qualified as a RGN in 1989. I specialized in two clinical areas: hematological and spinal injuries nursing. Moral dilemmas and problems seemed to pervade all nursing activities in both these specialist areas.

Between 1989 and 1992, I relished clinical nursing. But I also had a deep fascination and curiosity towards moral concerns in nursing. For example, (a) what are the moral issues involved when patients refuse life-prolonging chemotherapy?, (b) how ought I tell a patient that he is paralyzed and probably will never walk again? and (c) what does it mean to act in a patient's 'best interests'?

Because of this interest in nursing ethics, I left full-time clinical nursing to study for a degree in philosophy. I enrolled at the University of Sunderland for a BA (Hons) in Philosophy with History in September 1992. I continued to work part-time as a nurse, especially during the vacations. Continuing to work as a nurse meant that my interest and understanding of moral problems in clinical nursing could develop. Concurrently, I began

to study some of the major figures in western philosophy, for example, Plato, Aristotle, Kant and Mill.

After graduating in 1995, I registered part-time for a MA in health care ethics at the University of Leeds, England. Several highly respected moral philosophers taught on this course and I thoroughly enjoyed the intellectual challenge that it provided.

I had known Dr. Shaun Parsons since my nurse training in Darlington. He was employed as a lecturer in the Department of Psychiatry at the University of Newcastle upon Tyne. Through Dr Parsons, I was introduced to Professor Phil Barker. Soon after, I began teaching ethics to mental health nurses (1996-2001). During this period, I taught several experienced mental health nurses. Through sharing ideas and arguments, my understanding of ethical issues in mental health nursing developed.

I registered for the PhD on a part-time basis in September 1997. My initial idea was to examine 'The value and sanctity of human life in patients with mental illness'. I spent the first year of my candidature reading literature and writing a draft chapter.

**Delphi studies**

I was awarded a departmental bursary to organize and manage two Delphi[1] questionnaire studies, with a view to writing up the studies for publication. Professor Barker also asked me to review the literature in mental health nursing ethics. I reviewed approximately 30 articles. I was already aware that obligation-based moral theories were popular in both nursing ethics and nursing practice. But this belief was further supported from the findings of the literature review. In short, the focus was on 'ethical decision making' and the

'resolution' of moral dilemmas in nursing practice. In order for nurses to be 'ethical' the message was clear: nurses *must* 'abide' by moral obligations, rules and principles.

I began work on the Delphi studies in August 1998. By the end of February 2000, both studies were completed and written up. Both papers were later accepted for publication in peer-reviewed journals.

The first[2] Delphi study aimed to investigate the views of mental health nurses in relation to ethical decision-making. The central question was: 'how do you make ethical decisions?' Delphi studies utilize a questionnaire design. Three 'rounds' of postal questionnaires were sent to the participants. Written responses were organized into themes and categories. The second[3] Delphi study operated in the same manner as the first. However, the participants were nurse lecturers working in university departments of nursing in the UK. The general aim of this Delphi study was to gather information on the organization, teaching methods and content of ethics modules taught to pre-registration students of nursing.

**Motivations for the thesis**

Some of the findings from the two Delphi studies interested me. First, in the 'clinical nurse' Delphi study, the majority of participants were familiar with the phrase 'moral virtues'. This familiarity was superficial, which I expected; after all, these were clinical nurses, not ethicists. The responses suggested that nurses utilized the language of the virtues and vices in clinical practice. For example, terms such as 'well', 'honest' and 'fair' were used by the participants many times in their responses to the questions. It was also clear that the participants viewed themselves as participating in a 'caring' discipline. However, their ethical decision-making appeared to be reducible to three key notions: moral duties (or

obligations), patients' rights and legal duties (or obligations). The latter notion received the second highest number of responses (after moral duties). While I was aware of the importance of the Mental Health Act, this finding intrigued and concerned me.

In the 'teaching' Delphi, it was revealed that obligation-based moral theories, including consequentialism, deontology and the 'four principles'[4] approach to bioethics were taught by ten out of eleven lecturers. Information about the depth and breadth of teaching was not forthcoming. It was also revealed that only four out of 11 lecturers taught the virtues and virtue ethics. Furthermore, it was revealed that specialist lecturers in ethics were not employed to teach ethics to students of nursing.

These findings prompted me to think carefully about ethics, the virtues and the role of a nurse. Several questions came to mind. For example, do nurses need to have an awareness of the virtues to be morally good nurses? Why are the virtues and virtue ethics not taught to the same degree as obligation-based ethics in nurse education? I suppose the pivotal question was: 'why are nurses – who care for ill patients - taught to abide by moral (and legal) obligations rather than cultivate and exercise the virtues? One of the premises upon which this thesis is based is that for a nursing ethics to be adequate, it needs to begin with the *ill person* instead of emphasizing the nature and consequences of actions and omissions.

In the first submitted thesis (September 2002), I examined the virtues in relation to mental health nursing. I did this for three reasons. First, because of my existing interest in mental health nursing ethics. Second, because of the interest in this field shared by Dr. Parsons and Prof. Barker. And third, because I believed that the nature of the virtues and the merits of virtue ethics were most suitable for nurses who care for patients with mental

health problems and mental distress. However, in response to the comments made by my two examiners, in this resubmission I provide examples drawn from both adult and mental health nursing. I believe that this approach helps to illustrate the value of the virtues across different nursing specialties.

## Type of thesis

### Philosophical ethics

In the 'Preface' I mentioned that this thesis proposes a philosophical argument. This thesis is an example of applied philosophical ethics. Moral philosophy (or general ethics, as I refer to it in this thesis) examines the question of how persons *ought* to live. It examines human conduct by investigating the nature and justification of moral obligations, rules, principles and virtues. Philosophy is concerned with rigorous thinking including the development of plausible and defensible arguments.[5] This thesis is theoretical. I advance a moral argument that I hope others will find plausible. This thesis is therefore not the product of an empirical research study. However, some qualitative empirical research findings are cited to support or reject a claim.

## Plan of the thesis

This thesis consists of an 'Introduction', eight Chapters, 'Conclusions' and a 'Bibliography'. I shall now provide an outline of each chapter.

### Chapter 2 - Illness, narratives and the value of the nurse-patient relationship

I begin by examining several relevant and important themes in contemporary nursing practice. These are: illness and narratives; hospitalization and patients' emotions; the history of the nurse-patient relationship; contemporary views of the nurse-patient

relationship and empowerment; therapeutic nurse-patient relationships including helping relationships; the role of the nurse; and defining a 'good' nurse.

**Chapter 3 - The virtues in general ethics**

I turn to general ethics and examine: the history of the virtues, conceptions of virtues and the value of virtues in peoples' lives. One advantage and disadvantage of the virtue-based approach to morality is then described.

**Chapter 4 - A critique of obligation-based moral theories in general ethics**

I critically examine the role of moral obligations, rules and principles and obligation-based moral theories within general ethics. I examine the merits and disadvantages of consequentialism and deontology.

**Chapter 5 – The origins, development and tenets of virtue ethics**

I describe the origins and development of virtue ethics, the moral theory that places the virtues at the core of morality. Three tenets of virtue ethics are identified. Both supplementary and strong versions of virtue ethics are examined. I explore Aristotle's virtue ethics. The notions of moral character and moral education are examined. I consider the work of Hursthouse[6] on virtue ethics' account of action-guidance. Objections towards virtue ethics are identified.

**Chapter 6 – A critical account of obligation-based moral theories in nursing practice**

I provide a critical account of obligation-based moral theories in nursing practice. I consider the popularity of these theories in contemporary nursing. I examine examples of the deontic (duty-based) approach in the literature, including 3 tools to assist moral

decision-making. The 'four principles'[7] approach to bioethics is described and several flaws of obligation-based theories are identified and examined.

**Chapter 7 – Virtue-based moral decision making in nursing practice**

I develop an account of the virtue-based approach to moral decision making in nursing practice. This approach has 3 features: (1) exercising virtues (2) using judgement and (3) using moral wisdom. The latter consists of 3 phenomena: moral perception, moral sensitivity and moral imagination.

**Chapter 8 – MacIntyre's account of the virtues**

I describe and examine MacIntyre's account of the virtues as set forth in *After Virtue*.[8] I interpret his claims and organize these to form 3 theses. These are: T1 – the role and importance of MacIntyre's narrative conception of the self in morality; T2 – MacIntyre on practices, goods and the virtues; T3 – the role and importance of a tradition of enquiry in morality. Objections towards MacIntyre's account are examined.

**Chapter 9 – MacIntyre's account of the virtues and the virtue-based approach to moral decision-making in contemporary nursing practice**

Some of MacIntyre's claims are applied to the account of the virtue-based approach to nursing proposed in Chapter 7.

**Chapter 10 – Conclusions**

I end the thesis by summarizing the argument. Some of the problems of the virtue-based approach in nursing are re-examined. I note some points for further enquiry and research. Finally, some of the merits of the virtue-based approach are examined.

## Conclusions

I have explained the broad aim of the thesis and provided some background information to help the reader understand my perspective. I have provided an outline of each Chapter. The scene is now set for me to begin to argue for a strong virtue ethics in nursing practice.

## REFERENCES AND ENDNOTES

[1] For example see: H., A. Linestone & M. Turoff, *The Delphi method – techniques and applications* (London: Addison-Wesley, 1975); H. Sackman, *A Delphi critique* (Lexington, MA.: Lexington Books, 1975).

[2] A., E. Armstrong, S. Parsons & P., J. Barker, "An inquiry into moral virtues, especially compassion, in psychiatric nursing: findings from a Delphi study" *Journal of Psychiatric and Mental Health Nursing,* 2000, **7**, pp. 297-306.

[3] S. Parsons, P., J. Barker & A., E. Armstrong, "The teaching of health care ethics to students of nursing in the UK: a pilot study", *Nursing Ethics*, 2001, **8** (1), pp. 45-56.

[4] T., L. Beauchamp & J., F. Childress, *Principles of Biomedical Ethics* 5th ed. (New York: Oxford University Press, 2001).

[5] For a more extended discussion see, D., D. Raphael, *Moral Philosophy* 2nd ed. (Oxford: Oxford University Press, 1994).

[6] R. Hursthouse, *On Virtue Ethics* (Oxford: Oxford University Press, 1999).

[7] T., L. Beauchamp & J., F. Childress, *Principles of Biomedical Ethics* 5th ed. (New York: Oxford University Press, 2001).

[8] A. MacIntyre, *After Virtue – A study in moral theory*, 2nd ed. (London: Duckworth, 1985).

# CHAPTER 2 - ILLNESS, NARRATIVES AND THE VALUE OF THE NURSE-PATIENT RELATIONSHIP

## Introduction

In order to develop an adequate and plausible nursing ethics, it is insufficient to centre the theory on the nature and consequences of actions and omissions. It is necessary to examine the *person* who is *ill* and ask questions about the characteristics of nurses; the latter are in a position to *care* for the ill person. Obligations, rules and principles cannot in themselves care for ill persons; all of these deontic (duty-based) concepts require *application*. Therefore, it is crucial that one examines the sort of nurse one is.[1]

I begin by describing and examining several topics that are relevant and important in contemporary nursing practice. All of these topics are in some way crucial to my account of the virtues and the virtue-based approach to moral decision-making in nursing practice.

These topics are: illness and narratives; hospitalization and patients' emotions; the history of the nurse-patient relationship; contemporary views of the nurse-patient relationship and empowerment; therapeutic nurse-patient relationships, including helping relationships; the role of the nurse; and defining a 'good' nurse.

## Illness and narratives

Illness can affect humans at any point in the life span. 'Illness' is a broad term and by using it one is to some degree making a value judgment. For instance, distinguishing between illness that is life threatening, serious, but not life threatening, and other illness that might be referred to as 'minor'. This language is reductionist; it reduces the language

used by the patient, which often will express emotions, to scientific jargon. Therefore one does not always get a sense of how a particular illness might make one *feel*. Examples of life threatening illness include some malignant cancers and acute myocardial infarction. Serious illness includes diabetes and viral meningitis, although one can die as a result of the former if hypoglycaemia or diabetic coma results. The common cold is one example of minor illness. However, viral infections such as the common cold and notably influenza cause a lot of misery for the sufferer; illness like this can interfere with and cause problems in one's daily living.

During infancy and childhood, children are dependent on others - usually parents and guardians - to take care of them and help them to fare well in life. Later in old age the reverse might occur: children may be involved in helping and caring for their parents. During one's life, help and support is sometimes required from other people including one's spouse, friends, and family members. This need is intensified during periods of both physical and mental illness; here, humans need other humans to help them survive, recover and fare well.

Illness is one of the features that can characterize one's life; this is especially true if one suffers from prolonged and chronic illness, either physical or mental. The extent to which illness becomes part of, or takes over, one's life depends on several factors including the causation, symptamatology, and prognosis of the illness and individual personality traits and coping mechanisms.[2] Irrespective of these factors, illness becomes part of one's life story. Illness helps to define one's life and the sorts of lives people can live. An important point about illness is that it is a feature of human life that can be shared with others, through, for example, conversation. By sharing these experiences, people can construct a narrative account of their illness. This can help some people to find meaning in, and make

some sense of, their lives.[3]

When I reflect upon my life, memories of childhood and adult illness come flooding back. If I am representative of other people, then others might also reflect about their past and present illnesses. Upon reflection, I believe that during illness I felt bad because of the various symptoms of the actual illness. For example, during a bout of influenza I felt hot, clammy, cold, shivery, my entire body ached, and I was so tired that I literally could not manage to climb out of bed. I knew that I needed regular fluids and paracetamol. Or at least I wanted fluids and paracetamol, because I thought that these would help me feel better. My partner provided these for me. And when I wanted to moan, there was someone around willing to listen to me. Reactions to illness are varied and personal. My experiences have told me that I feel more upset during illness if there is no one around, no one asking me what I want and no one to listen when I give my response. I doubt that I am alone in feeling this way. Indeed reflecting on my previous nursing experiences and caring for relatives, I believe that other people feel similar to me regarding personal responses to illness and the need for help and support.

Physical and mental illness, life threatening and otherwise, and the consequent need for help and care from other people can strike at any stage in one's life. One of the few certainties of human life is that one lives each day without knowing when illness will afflict one. Illness becomes part of one's life and it can be constructed through a narrative.

## Hospitalization and patients' emotions

What are some of the many emotions that people might experience during hospitalization?

### Anxiety

Feeling anxious and worried is natural during illness. One might be anxious about the actual cause and prognosis of the illness. Being hospitalized exacerbates these feelings, because not only is one anxious about one's well-being, but there are also practical issues to worry about. For instance, the new physical environment of an Accident and Emergency (A&E) department or hospital ward and the many unfamiliar new faces and names of health care professionals to get used to. Depending upon the severity of symptoms, one might be worried and anxious about the possible disabling affects that the illness might cause. Separation from one's spouse, loved ones and family members might also intensify feelings of anxiety. These are just some of the many reasons why patients might feel anxious during hospitalization.

### Fear

Fear is an emotion that often accompanies anxiety; the two can be related in that if a patient is anxious she might also be frightened. Generally a lot of people appear frightened of illness, or at least the idea of being ill and the images that this can conjure up. For example, being less able to look after oneself, needing help, and suffering physical and emotional pain. Thinking about hospitals and the idea of being hospitalized also makes some people feel uneasy and fearful. This is, in part, because of the public perception of hospitals and the association between these institutions and ill people, disease, and dying. One generally realizes that being hospitalized means one is ill and one typically wishes to remain healthy (whatever that means for the individual).

Fear of illness, its effects on one's life and fear of hospitals can be contrasted with another sense of fear: fear of dying. For example, if one is admitted into A&E with severe, crushing central chest pain, dyspnoea (shortness of breath), palpitations, and nausea then it is plausible to think that one might be extremely frightened about dying. Let us imagine that this is the first time such symptoms have occurred. There is nothing to compare this situation to. It is difficult to imagine precisely how such a critical situation might make one feel. This person might feel frightened of dying because the symptoms, especially the chest pain, are so severe and cause so much physical pain. This person might not be able to make the link between chest pain and a serious heart problem. My knowledge of the heart and the fact that this is probably a heart attack would, I think, make me feel very frightened of dying; more so perhaps than if I had no idea of what was happening and what could occur, for example, a cardiac arrest.

A second example sees a person with leukaemia about to enter hospital for a third course of chemotherapy. This person is frightened because she reflects back on some previous distressing experiences of having chemotherapy; she remembers her hair falling out and how this made her feel when she looked in the mirror each morning, she cannot forget how painful her mouth was and how tired she became, so tired she never left her bed for 3 long weeks. This person is well aware of what might occur with the third course of chemotherapy (one of the reasons why some people might refuse more than one course of chemotherapy). This person is frightened of how she might be feeling in a week or two; she might also be frightened of dying as many people with cancer naturally are. But in this example, the person is dwelling on the nature of the treatment and especially its side effects and how miserable and distressed, both physically and emotionally, these made her feel. Despite individual psychological differences, I believe that many people wish to lead healthy, independent and valuable lives. The point I wish to make is that for these

people above, fear of dying from a heart attack and fear of unpleasant and distressing side effects from chemotherapy, are understandable and rational emotions to experience.

One point about the manifestation and experience of emotions is that these processes are complex; furthermore, they are subjective and as such one should refrain from making generalizations. For example, waiting six months for a septoplasty – a relatively 'minor' surgical operation in which the septum is reshaped to reduce nasal decongestion – gave me a great deal of time to think about the operation and general anaesthetic and more than enough time to think about possible mistakes, side effects and all manner of nasty medical calamities. Compare this example of elective surgery to an acute surgical emergency where a person with severe abdominal pain and signs of peritonitis requires emergency surgery to save his life. There is clearly less time to think about possible errors. But the acute nature of the situation, the speed and intensity in which the patient is prepared for theatre, and the serious – painful - nature of the illness will mean that this person will be anxious and frightened. It is reasonable to suggest that feelings of anxiety and fear will be experienced by many patients in varying degrees and manifested in different ways, depending upon the specific circumstances of the illness and one's experiences of hospitalization.

**Powerlessness**

Imagine lying in a hospital bed, alone, feeling anxious and frightened. Perhaps one has recently undergone abdominal surgery. Various physical symptoms might afflict one including pain around the wound site, nausea, vomiting, and extreme lethargy. Or perhaps one has informally admitted oneself to the local mental health unit feeling very depressed. One wants to talk to the nurses, but they all appear too busy. One is in a state of emotional distress. These feelings created by illness and all of the features imposed upon

one by the dehumanizing process of hospitalization[4] promote feelings of powerlessness; indeed patients might feel robbed of all power and control. If patients cannot exert any control over their illness, environment and care, or if this is possible but only to a minimal extent, then feelings of powerlessness might naturally develop. Feelings of powerlessness and loss of control can be a particular feature of chronic Illness, including chronic mental illness. In the words of Pellegrino and Thomasma

> sick persons must bare their weaknesses, compromise their dignity, and reveal intimacies of body and mind.[5]

Allowing nurses and other health care professionals access to one's body and mind might be necessary in order to survive and recover, but it helps to make people feel devoid of power and control; in other words, it can disempower people.

People tend to feel more comfortable and in control when they are at home or in other familiar surroundings. Feelings of powerlessness are common with admission or contact with mental health services. People with mental illness might, depending upon several factors including the nature of the illness, symptamatology and degree of insight, feel devoid of all power and control. Or one might believe that one has little input into what is happening *to* one (rather than *with* one; the former connotes a sense of non-collaborative care). In such cases, the emotions of powerlessness and loss of control can be deeply upsetting feelings.

Thus far I have looked at why patients might feel anxious, frightened, powerless and lack control and how these feelings can affect one. Crudely, these negative emotions can be triggered by the illness itself and then intensified due to the dehumanizing process that hospitalization can be.

### Vulnerability

Patients in hospital are often described as being vulnerable.[6] One might feel vulnerable because one is aware that there is potential to be hurt – meaning, physical pain and emotional distress. One's survival might literally be in others' hands. Feelings of fear and powerlessness will perhaps contribute to a general sense of feeling vulnerable: being wide open to harm. After all, what could a patient do to prevent others from physically or emotionally causing him harm? Preventing physical harm might appear to be easier. For example, one can usually see that an action is about to happen, such as, a nurse approaching with an injection. Here, one can refuse the injection and prevent the physical harm caused by the needle puncturing the skin and penetrating the muscle. At other times, the physical harm occurs as a consequence or side effect of interventions such as medications. This sort of example is more difficult to prevent. What is quite clear, however, is that a patient has no control or power over the *language* that a nurse might use. In other words, *what* a nurse says and *how* this is phrased is under the control of the nurse. Patients have no control over nurses' language and phraseology.

#### Vulnerability and trust

One of the effects that vulnerability has upon patients is that it forces one to trust others. Trust is sometimes spoken about as if it could be voluntary. But in reality patients have little choice in the matter; as Pellegrino and Thomasma[7] claim patients are forced into trusting clinicians. Even though nurses and health care professionals are qualified and usually well trained, they are strangers to the patient especially during the initial assessment phase. This begs the question 'why should I trust someone whom I don't know at all?' In a social setting, few of us would trust a total stranger. But if there were no choices open to one and the only alternative was death, then one would probably be forced to trust another person. Suppose I meet someone at an office party. But after

spending a little time with this person, I decide that I dislike him. But then a fire breaks out. Everyone panics; no one appears to know what to do. However, the person I have just met (and dislike) does not panic. In fact he calms me down and ensures that we both get out without injury. I had decided that I did not like him, but I needed to trust him because everyone else was panicking and he seemed to know what he was doing. I was scared and panicking because I had no idea how I was going to descend the 12 flights of stairs.

Patients in hospital can be forced to trust nurses. Nurses are trained to a certain standard that helps to ensure competence to practice. Frequently, patients believe that nurses possess certain 'caring' personal qualities such as kindness, patience, and gentleness. It is hoped that patients will trust nurses because of the characteristics and personal qualities that nurses demonstrate. However, ultimately, because one is ill and needs help to survive and recover, patients are forced to trust nurses. There is really no alternative unless one decides to discharge oneself. However, for most patients self-discharge is not a viable option. This is because patients tend to want to survive and recover and thus self-discharge would be an irrational act; if by rationality one means doing that which promotes one's interests.[8]

Trust, as an aspect of the nurse-patient relationship, is a complex notion that has been examined by several nursing scholars.[9] In feminist moral theory Baier[10] has written widely on the notion of trust. She claims that for a moral theory to be adequate and sufficient for both men and women it needs to include the notions of love and obligation; crudely the former will satisfy what most women want in a moral theory while the latter satisfies what most men want in a moral theory.[11] Baier argues that trust could be the notion that satisfactorily encapsulates both love and obligation. On her view trusting nurses concerns relying on their competence; nurses ought to be willing to care for patients who are

entrusted to their care. In loving relationships, one trusts another not to harm one, while in relationships founded upon obligation – as nursing is frequently conceived – patients trust nurses to be competent and fulfill their obligations.

**Dependence on others**

Depending upon one's condition, one might need to allow nurses direct contact with one's body, often involving intimate touch. If one is ill and hospitalized, then help is needed from nurses to meet one's needs. Of course one need not be hospitalized to require help: a patient with multiple sclerosis[12] living at home needs twice daily visits by community nurses and support workers to help with most of her needs. For example, sometimes she cannot manage to get out of bed without help, she often needs help with cooking and cleaning, and she always needs help to get bathed and dressed. Patients are *dependent* on nurses to help them meet their physical and non-physical (for example, emotional) needs. Patients are reliant on nurses to relieve distressing symptoms, promote independence and enable recovery (I focus in more detail on the role of the nurse later in this chapter). Whilst one might not *want* other people to carry out intimate interventions, one recognizes that without such necessary actions the illness might persist or worsen; thus one generally realizes that these interventions are medically necessary. Nevertheless, it might be that beneath the appearance of voluntariness, lies the fact that patients feel *forced* to trust that nurses are clinically competent and motivated by morally good desires.

## A brief history of the nurse-patient relationship[13]

Since the middle part of the 20th century the nurse-patient relationship - seen in terms of human interactions, excellent communication skills, and mutual cooperation - has emerged as central to nursing practice. But at the beginning of the 20th century, patients

were viewed and understood as objects of medical and thus nursing interest. According to Dingwell *et al*[14], nurses were involved in servant-master relationships with medical professionals and nurses had an important role in medical surveillance of the body.[15]

There was no real concern with nurse-patient interactions or with personal knowing. Indeed evidence[16] suggests that institutional practices sought to regulate and constrain nurses' interactions with patients. All nurses with the same position and training were considered as equals[17]; all patients were regarded as equal too. Nursing was seen as a 'collective accomplishment'[18] and individual relationships were subsumed within this belief. Personal and professional aspects of nurses were deemed as mutually exclusive. The personhood of the nurse lay outside her professional role; the personhood of the patient was also deemed to be outside the nurse-patient relationship.

From the 1960's, Armstrong[19] argues that a fundamental change occurred in the development of the nurse-patient relationship. The broadening knowledge base in human psychology and communication theory led to the patient being viewed as a bio-psychosocial being. The idea of a person with physical, psychological and social needs crossed over into emerging nursing theories, education, and practice. The patient was now seen as a complex subject (rather than *just* an object) of nursing care who needed to be understood; as a result the nurse-patient relationship in this humanistic sense became a central theme in nursing theory.[20] Surveillance became not just a matter of physical identity but now focused on the patient's bio-psychosocial identity too. Instead of nursing theory and practice being seen solely in physical or medical terms, it developed a holistic person-centred[21] meaning and identity. The organization of nursing work changed from task allocation to individual patient-focused care. As a result, closer more intimate relationships between nurse and patient could develop.

## The nurse-patient relationship in contemporary nursing and the notion of empowerment

Feelings of powerlessness, helplessness, vulnerability and dependence on others for help ensure that the nurse-patient relationship is an unequal one; it is a form of inequality "paralleled by few other situations in democratic societies". [22] It is, for many thinkers, the core of nursing and medical practice. For example, according to Pellegrino and Thomasma this relationship is

> the moral fulcrum, the Archimedean point at which the balance between self-interest and self-effacement must be struck.[23]

All nursing activities and interventions are enabled through the development, delivery and sustenance of the nurse-patient relationship. However, it has already been noted how the inequality that lies at the heart of this relationship contributes towards feelings of powerlessness in patients. Therefore, one of the main issues that needs to be addressed in the nurse-patient relationship is the notion of empowerment.

The notion of empowering patients is a prominent feature of the current nursing literature.[24] At least three points emerge from thinking about the notion of empowerment. First, like most notions that become popular in health care it is much more complex than it at first might seem; this notion requires one to think from several different perspectives such as medicine, psychology, sociology, economics and ethics. Second, despite this complexity one can identify two general points: (a) the idea that nurses can only empower patients if nurses themselves have sufficient power and authority and (b) the idea that nurses should aim to provide a physical and emotional environment that is conducive to patients being able, if they so wish, to make their own decisions. The third and final point is that the identification and examination of moral virtues needed to be morally good nurses, and specifically virtues required to empower patients, is neglected in the literature.

Mental illness (or mental ill health[25]) is disempowering because one's ability to function day to day is adversely affected by what Barker calls 'problems of living'[26] or the medical model might call 'symptoms of mental disorder'. If these features of mental ill health persist or reoccur then the term 'disabling' is given and the phrase 'chronic mental illness' is often applied too. Clearly, physical illness can also adversely affect one's quality of life. For example, chronic rheumatoid arthritis (CRA) causes pain, deformity and spasticity in the sinovial joints.[27] Living with such an illness must be difficult. People with CRA tend to require medical help in the form of anti-inflammatory medications to reduce swelling and promote mobility. The primary focus is on helping the person to meet his needs and retain a sense of independence. But no matter how much these aims are achieved, there remains an element of feeling really dependent on other people; one must rely on other people, for example, GPs, nurses, and carers, for one's needs to be met. Thus one might feel vulnerable and powerless: one is unable to change the fact that one has arthritis nor can one do much about the course of the illness as it is progressive. However, it is not only the nature or effects of the ill health that contributes towards feelings of disempowerment. The actual organization and structure of the National Health Service (NHS), including primary and secondary care, and specific care and treatment processes such as hospital ward policies and those imposed involuntarily through the Mental Health Act[28] add to the feelings of being disempowered.

Latvala, Janhonen and Wahlberg[29] described 3 different forms of helping used by mental health nurses, which point to different power dynamics in the nurse-patient relationship. 'Catalytic' helping is described as involving participatory dialogue, mutual collaboration is developed in part because the patient is deemed to have responsible agency. 'Educational' helping is different. Here precedence is given to nurses' knowledge and professionalism, an assumption being that the patient is a responsible recipient, the

relationship in this form of helping is driven by the professionalism of the nurse. The third type of helping is termed 'confirmatory'. These methods are based on the assumption that mental ill health arises from a physical cause, the patient is a passive recipient of information and thus the nurse-patient relationship and cooperation is limited by this belief and the hierarchical structure of care services. It is clear from this discussion that empowering patients involves a series of actions and choices that involves nurses making moral judgments. Several factors need to be taken into account including one's values, beliefs, clinical experience, and knowledge. For instance, regarding the first and second factors, a nurse needs to identify and examine her values and beliefs about the cause of a patient's illness and the role that that patient can and should play in their care. I discuss virtue-based moral decision-making and the role of moral wisdom in Chapter 7.

Each patient has an individual and unique story to tell. This is the patient's lived experience of the illness. Given the importance of and value attached to the nurse-patient relationship and the benefits of patient-focused care[30], I suggest that nurses should allow patients to tell their stories and in so doing a narrative account of their illness can be provided. Disempowerment can arise because the person is not allowed to tell such stories. Or perhaps the appropriate questions are posed, but no one is listening to the patient's conversation. Therefore, no one can learn how the ill health is causing specific problems of living or how the illness is generally affecting the patient's life. It is not difficult to begin to understand how patients might feel if they are not given the opportunity to tell their story.

**The medical model and disempowerment**

Tilley[31] notes the importance of getting people and their loved ones actively involved in their care, if this happened then perhaps people would feel more able to tell their stories.

The Department of Health[32] too want to alter the power balance of the practitioner-patient relationship and generally the theme of collaborative care is high on the health care agenda. But, for some, contemporary mental health nursing practice remains subordinate to the medical model and psychiatry. This view holds that nurses are still the foot soldiers to the generals'[33] (the doctors') plans against mental illness. It is true to say that the medical model is primarily concerned with clinicians making diagnoses, delivering treatments, and identifying and evaluating the outcomes of disease processes. Epistemologically, the medical model is empirical and reductionist in nature. One of the limitations of the medical model is that a patient's lived experience can be neglected. Perhaps the necessary questions are not asked or no one listens when the patient attempts to describe and make sense of his illness. The language of medicine is reductionist and this can mean that individual accounts given by patients might not be fully heard. The emphasis is on the disease process and patients' feelings and emotions can be lost in the benevolent rush to diagnose and treat the disease. I am not saying that all or even the majority of clinicians ignore or neglect patients' feelings, that would be far too crude and inaccurate. However the use of medical language does not promote the identification and examination of patients' feelings and emotions, which are usually seen as subjective and personal notions. Ideas and initiatives in vogue such as patient-centred care and the concept of holistic nursing are in large part a reaction against the reductionist approach of empirical medicine. If the medical model is utilized and applied in a singularly scientific manner, then it can hinder the process of patients telling their narratives.

**The Tidal Model and empowerment**

Nursing models[34] [35] have attempted to adapt general nursing theories to mental health nursing. However, The Tidal Model[36] emerged from a previous study that posed the question: 'what do people need mental health nurses for?' From this a substantial model

of nursing practice in mental health care was generated. Included within this model is the notion from Peplau[37] about the importance of interpersonal interactions. Furthermore, there is recognition that an effective and complete model requires an emphasis on the process of empowerment within the nurse-patient relationship.[38] The Tidal Model proposes that the construction of the patient's lived experience occurs through narrative, which is allowed to develop through the nurse-patient relationship. The Tidal Model is one attempt to put the person's lived experience and narrative centre stage and in so doing the person can be empowered. The Tidal Model aims to refocus nursing practice on the human needs of people in mental health care. It investigates such notions as personhood, mental distress, and the assumption that recovery for many people is possible. Both intrapersonal and interpersonal resources can be used to promote the process of recovery.

**Therapeutic nurse-patient relationships**

There is an abundance of literature on the nurse-patient relationship. [39] This relationship is usually termed 'therapeutic' as in a therapeutic nurse-patient relationship or a therapeutic alliance. This literature discusses several ideas including (a) phases of the nurse-patient relationship, for example, the initial or assessment phase, the working phase and the termination phase, (b) distinctions between social and therapeutic relationships, the latter have distinct aims characterized by the notion of helping another person, and (c) examples of communication skills such as empathy and compassion, which it is argued nurses need to develop therapeutic relationships with patients.

How can a therapeutic relationship be defined? Ironbar and Hooper provide one conception,

> The goal, which will take skills and time to achieve, is a therapeutic

> nurse-client relationship, i.e., one in which the client is enabled to work through his problems, maintain his individuality and to learn from his experiences.[40]

Several texts (see endnote 39) comment further and list skills that nurses should acquire to develop and sustain therapeutic nurse-patient relationships. Among these skills are responsiveness, promoting self-esteem, acknowledging the uniqueness of the patient, maintaining confidentiality, making non-judgmental responses, developing trust and empathy, and providing support for patients.[41] Yet more thinkers focus on describing processes involved in communication and explain why it is important for nurses to have theoretical knowledge of communication theory. One example, among many, of this approach distinguishes between verbal and non-verbal communication theory.[42] For example, regarding verbal communication, nurses need to think about several aspects of communication including the clarity of one's voice, the brevity of the language, the vocabulary used, and meaning, pacing and intonation. Non-verbal communication includes issues such as personal appearance, facial expression, posture, gait, gestures, and the use of touch. Skidmore[43], for one, believes that all of these points are important to facilitate therapeutic relationships. Moreover, he thinks that the notions of reception and understanding are especially vital. For example, 'reception' refers to full commitment on the part of the nurse to listen in full to what the patient is saying, while 'understanding' refers to hearing what patients say and then making sense of this information.

The objectives or ends of therapeutic relationships are varied and contextual. These can include helping a patient into recovery and promoting self-esteem and independent living.[44] Possible ends in, for example, cancer nursing might include relieving physical pain, helping a patient to cope with the distress caused by the illness and the treatments including radiotherapy and chemotherapy and helping a patient towards a good death.[45]

### Helping relationships

Literature notes that a 'helping' relationship is an example of a therapeutic relationship and the 'dimensions' of a helping relationship are sometimes outlined. [46] For example, nurses need to be trustworthy and honest to form helping relationships. However it is interesting to note that there is no acknowledgment that these dimensions are examples of moral virtues. Furthermore, there is no insight into how so-called 'communication skills' and 'dimensions' of communication can be seen from other perspectives including those of morality. It is common for the conception of a helping relationship to be articulated in terms of pure communication theory. Human interactions, human responses and the role of moral virtues in developing a helping relationship between nurse and patient are not mentioned. There is a general failure to relate communication, both its theoretical and practice elements, with the moral lives of patients and nurses.

## The nurse-patient relationship: empirical research findings

There is a wealth of qualitative literature that examines the nurse-patient relationship. For example, a recent Delphi questionnaire study[47] posed the question: "Describe what you do, think, and feel when you build a relationship with a patient?" Seven themes emerged from the 89 points made. In ranking order, these themes were:

1. Getting to know each other;
2. Being open and honest about roles and boundaries;
3. Be friendly towards client;
4. Recognizing how this person [this client] makes me feel and making sense of this;
5. Showing respect for a person's experience, choices, lifestyle;
6. Develop trust;
7. Give empathy and sympathy.

These themes all involve or concern either intrapersonal or interpersonal skills or the inculcation of moral virtues. In the same study participants based their practice, in part, on moral virtues such as compassion, honesty and justice.[48] However, the precise technical term 'moral virtue' meant little to the nurses. But what is in a name? In other words, why does it matter if compassion, honesty, and justice are not understood explicitly as moral virtues? From a clinical nursing perspective, I want to see nurses demonstrating moral virtues, for instance, kindness, justice, and patience. It matters much less if a particular nurse is unable to articulate a theoretical knowledge base regarding the meaning of a moral virtue. There is no correlation between someone's depth and breadth of knowledge concerning, in this case, the virtues and the reality of *how* one does act, think and feel. However, if these virtues are known by thinkers as dimensions, then one effect is to gloss over the actual complexity of the virtues; how difficult it can be for people, including nurses, to inculcate these, why it is important that the virtues are inculcated, and how nurses can use the virtues to make morally good decisions.

Part B of this question asked: "What factors might (a) support and (b) restrict this process [building a therapeutic relationship with clients]?" Reponses for (a) included "taking an interest in people", "being available to listen to the patient", "good communication skills", and "being honest". All of these responses were behaviours, actions and choices that *nurses* had control over. Other responses were given which the respondents believed *patients* had control over, for example, "a willingness for the client to engage in the relationship" and the "communication skills of the client". Responses for (b) included "lack of respect (or trust) of the client", "poor communication, e.g., listen too little", and "poor explanation of the role of the nurse". These points were recognized as behaviours or qualities within the control of and influenced by the *nurse*. Some of the factors that might restrict the building of a therapeutic relationship and under the control of the *patient* were

"severe illness", "[clients who are] resistive to involvement", and "[clients] having a bad experience with others". Human responsiveness and the role of the virtues are again seen to be valuable aspects in forming a therapeutic nurse-patient relationship.

**The role of the nurse**

Describing and clarifying the role of the nurse is complex and is not conducive to generalization. It is quite clear that a contemporary nurse will need to take on several sometimes different or even incompatible roles (one simply has to read a typical list of roles that is attached to a nurse's contract of employment to see the variety). But being precise about nurses' roles does not necessarily mean that only one or two roles should be explicated. What would be the advantage of doing this? It seems to me unnecessary and futile to both individual nurses and the profession to strive for such an objective. Specifying the role of the nurse might provide nursing with a specific identity. For some nurses, depending on the role identified, this might promote the notion of nursing as an independent profession, able to break from the shackles of medicine. But by confining nurses to a discrete role – for example, helping patients recover from illness – it could be argued that both nurses' professional and personal autonomy could be threatened. However such a vague role as 'helping patients recover from illness' could be conceptualized and delivered in such a wide variety of ways that the role would be almost meaningless. I doubt that it would constrict personal qualities and abilities such as the capacity for independent thought, one's ability to make judgments, and the promotion of clinical innovation; all of these qualities are thought important to being an effective professional nurse.[49]

I have led teaching and learning sessions with both student and qualified nurses, both mental health and adult branches, and as anticipated, there is some degree of divergence

regarding the role of a nurse.[50] Specific roles will depend on one's working environment; for example, the roles expected of a theatre nurse will differ from those of a community nurse or mental health nurse working on a forensic unit. However, it might be possible to find some convergence of opinion about generic roles that the majority of nurses are expected to meet. From some teaching that I have led, examples of these include 'nurses care for patients' and 'nurses should educate patients about their illness'. As noted, several nursing thinkers claim that one role of the nurse is to utilize intrapersonal and interpersonal skills to facilitate a therapeutic nurse-patient relationship. Another common role articulated in the literature concerns the nurse as someone who is aware of and meets the various physical, psychological, spiritual and social needs of the patient.[51]

**The role of the nurse: some empirical findings**

Several empirical studies have investigated the role of the nurse or looked closely at the aims of being a nurse. A recent Delphi questionnaire study[52] revealed some findings about the aims of mental health nurses and beliefs about the formation of therapeutic nurse-patient relationships. For example, one question was "what do you think are the main aims and goals of being a mental health nurse?" This question was posed in round two (there were three rounds in total) when 22 mental health nurses participated; 15 females (68%) and seven males (32%). Eighty-three points were given in response to this question. From these, nine different themes were identified. The most popular themes were:

1. To educate, support and treat people with mental health problems using a range of therapeutic interventions;
2. Utilize skills and knowledge gained through training and life experience to help people who suffer from mental illness;
3. To work with other professionals and outside agencies and the general public to destigmatize mental illness;

4. To see the client as a person, encouraging them to identify their strengths;
5. Developing a rapport and relationship with people.

In this study the notions of being therapeutic and helpful are expressed in 1. and 2. respectively, 4. points to the idea of providing holistic nursing care, while 5. indicates the importance of an effective nurse-patient relationship.

Another Delphi study supports some of the findings from the one above. This study sought to investigate the required role of the psychiatric-mental health nurse in primary health care.[53] Thirty professionals participated in the study including community psychiatric nurses, general practitioners, social workers, purchasers and service managers; six participants from each profession were recruited to the study. Following the first and second questionnaires, interviews were held with the professionals. Users of mental health services were then also enlisted and questioned so that the emergent findings could be verified. The main theme or core category was 'relationships'. It was believed that to provide effective mental health care nurses needed to develop strong relationships with patients and other professionals. The importance of the nurse-patient relationship, as espoused by thinkers such as Peplau[54] and Altschul[55] was enforced by this Delphi study; in the authors' words

> There was a view that the value of the nurse-patient relationship was as great, if not greater, than the value of any clinical interventions.[56]

Another recent small-scale study gained qualitative data from users of mental health services. The research question was "What do mental health nurses need to be, do, or know?" One of the groups interviewed (n=8) responded with comments that included "show respect and a genuine interest", demonstrate certain traits such as "kindness,

gentleness and sensitivity" and "take time to talk and explore difficulties".[57]

The above three qualitative studies investigated the views of clinical nurses and patients in an effort perhaps to describe the reality, not the rhetoric, of nursing for *these* nurses and to ask *these* patients' what they wanted from nurses. The emerging themes are not reliable. For example, if other researchers followed the same methodology for each study then the findings, in different parts of the UK with different participants, might well be different. So I am not claiming that other nurses and patients from different wards or different geographical locations would concur with the views from these three studies. Although given the literature and the findings from these (and other) studies, it is reasonable to think that there would be some degree of convergence. The themes from these three studies include (in no particular order):

- responding to patients as individuals;
- demonstrating respect towards patients;
- the importance and value of 'relationships', held by some patients to be as great if not greater than the value of other clinical interventions;
- the need to make oneself available to patients and spend time with them to ask questions, listen to their responses, and really hear what they are saying;
- the need for nurses to demonstrate certain traits of character – moral virtues – for example, kindness, patience, and honesty.

**Barker, Jackson and Stevenson[58] on the essential feature of mental health nursing**

Barker *et al* recently conducted a modified grounded theory[59] study that broadly investigated the need for, and the role of, psychiatric nurses. Ninety two participants including users, family members, friends, and mental health professionals took part in a series of focus groups held in two sites in England, two sites in the Republic of Ireland,

and two sites in Northern Ireland. Theory was generated from participants' statements. Some consensus was provided from both participants and professionals that the "essential feature of nursing"[60] – the core category – was a complex series of relationships termed 'Knowing you, Knowing me'. Barker prefers to use the terms 'person' or 'people' instead of 'patients' or 'clients'. Three domains of relating were elucidated from this study that "serve as context-dependent bases for the adoption of differing roles designed to meet the person's needs".[61] These domains were 'Ordinary Me (OM), 'Pseudo-Ordinary [or Engineered Me] (POEM), and 'Professional Me (PM). OM "relied on a natural ordinariness" from the nurse, POEM "involved a more discretely *conscious* presentation of the nurses' 'self', while PM "is the domain where the nurse did what (s)he considered 'best' for the person: the evidence-based domain".[62] Distinguishing between these domains of relating were 4 internal dimensions: depth of knowing, power, time, and translation.

**Depth of knowing**

All of the participants stated that nurses *know* people best because of their greater contact time. However an extensively broad range of knowledge concerning a person might also be superficial in terms of depth of knowledge. The people in this study challenged the belief that too much emotional involvement could be unproductive.[63] Within the OM domain, people wanted nurses to be more intimate and share information about themselves. Often this relationship was one way; as a consequence people lacked motivation to disclose information to nurses considered to be 'blank screens'. While some nurses were comfortable sharing information about themselves within the OM domain, others were not; this was viewed as a burden and emotionally draining.[64]

**Power**

Regarding the dimension of 'power', differences emerged between the domains of relating. The OM domain involved a sense of caring 'for' someone, while caring 'about' lay within the POEM domain. Barker and Whitehill[65], while recognizing that caring can include domination by carers, believe that caring 'with' involves active person and nurse collaboration. However, caring 'for' someone "in such a way as to help them take reasonable risks...was seen as empowerment".[66] Within the POEM domain, nurses might hold considerable power but by exercising friendly dispositions, they can win a person's confidence and thus might be able to work on specific therapeutic issues.[67] The nurses in this study did not form friendships but acknowledged being 'friendly'

> I think that you can be friendly without building a friendship ....our role isn't to socialise. There is a goal and we must look for it. I don't see a problem with being friendly to achieve some other goal. (Nurse, group F).[68]

The last part of the above sentence is interesting and indicates to an extent a means to an end approach from the nurse. In some situations, this could involve an element of deception or dishonesty, but this might be – as above – justified from the nurse's point of view if a certain goal or outcome is achieved. This relates to the more general theme of needing to be a different nurse to suit individual patients depending upon their needs and expectations. A contemporary conception of the nurse-patient relationship includes the notion of nurses being authentic and genuine[69] and intimate and empathetic.[70] Arnold[71] among others believes that an absence of authenticity leads to a sterile application of communication techniques. However, Aranda and Street[72] claim that problems are created from the view of nurses as authentic. Conflicts arise in nurses who desire to be authentic and a sense of emotional discomfort and distress afflicts some who feel that in certain complex emotional situations they need to become the sort of person that the patient

requires or in their words they need to be 'a chameleon'. These are clearly emotionally turbulent situations and these reflect one of the difficulties for contemporary nurses in balancing their many, sometimes conflicting, roles.

**Time**

The third dimension was time. Within the OM domain the use of time was valued as an essential aspect of this domain. It was believed that if nurses spent less time with people then they removed themselves from intimate knowing. Reference was made several times to nurses being unavailable on wards

> They [the nurses] sit in the office and patients are outside and whether going through distress or whatever, you knock on the door and say can I see somebody. 'You can just wait. You'll be all right. Just go and have a cup of tea. (Person, group A).[73]

The situation was different within the community setting. Even though the nurses might not spend a lot of time with the person, there were fewer distractions. Community nurses were perceived as having a wider appreciation of families and engaged in more informal and friendly relationships.[74] From the perspective of patients' relatives, the quality of nursing care is affected by several factors and qualities including taking time to get to know the client.[75] According to the latter small-scale ethnographic study that interviewed 12 relatives, other issues recognized as important to high quality care were working *with* the client and nurses having positive attitudes – even love – for clients.

Some observational literature makes interesting if perhaps surprising reading regarding the amount of time nurses spend in contact with patients. For example, Altschul[76] found that only 8% of psychiatric nurses' time was spent in one to one interaction with in-patients. According to Sanson-Fischer, Poole and Thompson[77] only 15.9% of nurses' time

was spent on one to one therapy, while Martin's[78] study revealed that in patients spent only 6-12% of their time interacting with staff. In a more recent qualitative study by Jackson and Stevenson[79], patients stated that they needed time to talk through their problems with nurses. In this study, patients said they valued time more than other interventions utilized in hospital; this supports the finding from the Walker *et al* study where patients believed that the value of the nurse-patient relationship was as great, if not greater, than other clinical interventions. According to Hurst and Howard[80] nurses spend more time on administration duties than they do interacting with patients. In the Jackson and Stevenson study, patients stated that they were unlikely to ask nurses for their time and were reluctant to disturb nurses if they were busy. In a recent observational study of 20 staff nurses on 3 admission wards in a psychiatric hospital, Whittington and McLaughlin[81] found that less than half of the working day (42.7%) was spent in direct patient contact. The study also demonstrated that

> the proportion of work time which was devoted to potentially psychotherapeutic interactions with patients was very small (6.75%).[82]

**Translation**

Translation was the fourth dimension in the Barker *et al* study. Within the OM domain, people and their families wanted nurses to be honest. Truth telling, for example, describing honestly the side effects of medications to people, was valued greatly within these relationships. Nurses were expected to be able to interpret technical jargon and be multilingual, for instance, conversing without difficulty with professional colleagues and also able to converse well with people and their families.

**Defining a 'good' nurse**

The contemporary definition of a 'good' nurse includes the cultivation of certain personal qualities such as self-awareness, the ability to reflect about practices, including self-reflection, and the demonstration of highly developed interpersonal skills.[83] In a recent Delphi study,[84] one question was: "What is it to be a 'good' mental health nurse?" Eighteen respondents (81.8%) stated that this was concerned with (a) practical skills, (b) clinical experience and (c) moral qualities. No one suggested that the development of competent practical skills was related to how long one had been a nurse. Two of the responses were "moral qualities and moral experience affects how a nurse delivers these practical skills, as it is about who she [the nurse] is as a person" and "It is a mixture of both but mainly it is the moral qualities and experience. To be honest and respectful of the client". The latter respondent made the point that knowledge and experience gained in practice and used to benefit the patient was therefore a moral 'thing'; I would prefer the term 'enterprise', but the point is well made and understood.

Three respondents stated that practical skills and moral qualities were both important to being a good nurse, however a third factor "general life experiences" was necessary too. For example

> Skills, experience and general life experiences would be my main positive aspect, feeling you could offer people help from known experiences. Though moral qualities would still be an important issue which would help me examine, [and] improve my standards of care.

In the above quote, the respondent appears to believe that moral qualities include intrapersonal skills such as self-reflection and reflection of one's practice, and that these can be utilized to promote one's own caring abilities or competence. Finally one respondent stated that being a good mental health nurse concerned *only* the importance

of moral qualities. She seemed to indicate the value of making a connection with a patient and generally the value of holistic nursing care, in her words "A good nurse is someone who can identify with patients and regard them as people in their own right".

Empirical research findings suggest that patients have their own views regarding what constitutes 'good' or 'high' quality nursing care. One small-scale study[85] involved interviewing 24 patients with mental health problems from 2 admission wards of a psychiatric hospital. Qualitative analysis revealed 239 indicators of high and low quality nursing care, which the authors categorized into 6 main themes. One theme was 'communicating caring' and this comprised 3 sub-themes, 'being available', 'listening' and 'actions explained'. Under the first sub-theme 'being available', the responses indicated that the patients valued the nurses as caring if they made themselves available to the patients. Nurses' actions that were particularly appreciated by the patients included setting time aside to be with patients and nurses' attempts to understand patients' problems. Another major sub-theme of 'communicating caring' was 'listening'. Several patients said that it was more important to them that nurses listened to their conversations than what the nurses actually said in response. Some negative experiences of not being listened to were described in the interviews. One patient remarked

> There's one nurse, if she sits and talks to you she is always looking around to see if anything is happening....she's not really bothered with what I'm saying and will come up with any answer just to shut me up.[86]

Theme 6 was termed 'nurses' attributes'. In this theme, the patients described the personal qualities, which they believed contributed to high quality nursing care. Examples of these traits were 'being caring', 'friendliness', 'kindness', 'patience' and 'tolerance'. In this study, patients with mental health problems were able to sense and perceive virtuous

care, that is, care motivated and exercised from moral virtues such as kindness and patience.

## Conclusions

This chapter has described and examined several areas of nursing practice, which help to lay the foundations for the remainder of this thesis. Several conclusions can be drawn from the preceding discussion. First, illness can affect one at any point in the lifespan. Illness becomes part of the person, it is therefore a personal phenomenon. Second, illness, whether it is life threatening or not, causes a range of emotional responses in the person. These responses include feelings of anxiety, fear, helplessness, powerlessness, and vulnerability. These feelings can be intensified with admission to hospital. Ultimately, when one is hospitalized one is dependent upon help from others, including nurses, to survive, recover, and fare well. Third, there seems to be a relationship between human vulnerability caused by illness and human dependence on others for help. And as MacIntyre[87] points out this relationship has been ignored in moral philosophy. I would also suggest that this relationship lacks sufficient discussion in much of the nursing ethics literature.

Literature reviewed, including both theoretical and empirical, agrees on certain characteristics of a therapeutic nurse-patient relationship. These include the idea that this relationship should be patient-centred and one of mutual collaboration. The role of the nurse is a complex topic and if one wishes to be accurate about this area of practice, then it is not particularly helpful to make assumptions or generalizations. From a review of literature, including both theoretical literature and qualitative studies investigating the role of the nurse, and anecdotal evidence from my own clinical practice and recent teaching sessions, there are however several areas of convergence. Broadly these include the idea

that nurses should help the patient to survive, recover and promote the patient's independence. Being a 'good' nurse and providing 'high' quality care from the perspectives of nurses', patients' and patients relatives' tends to centre on several personal attributes, qualities or skills. These include: the need for nurses to develop and demonstrate good communication skills, both verbal and non-verbal, the need for nurses to demonstrate certain personal qualities or 'dimensions' such as trustworthiness, honesty, patience, and kindness, being friendly towards patients, treating patients with respect, and meeting patients' individual physical and non-physical needs (holistic nursing care).

The nurse-patient relationship as conceived above is held by patients to be extremely valuable, as valuable, if not *more* valuable, than other clinical interventions. It seems to me that this kind of helping relationship is only achievable if nurses make themselves available to patients, spend sufficient time with patients, allow patients to tell their stories, listen to patients' stories and try to hear what they are saying. However, the literature examined suggests that nurses are spending most of their time doing administrative tasks and only a small proportion of their time is spent in direct contact with patients.

In Chapter 3, I turn to general ethics and examine the virtues.

# REFERENCES AND ENDNOTES

[1] In the course of this thesis, I shall elaborate on these claims and explain in more detail my reasons for these claims.

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[21] The literature on holism and holistic nursing care is plentiful. See, for example: S. Woods, "Holism in nursing" in *Philosophical Issues in Nursing* ed. S., D. Edwards (London: Macmillan, 1998), pp. 67-88. The concept of holism began as a reaction against the medical model of medicine and has become a major issue in both nursing theory and practice. The notion of holistic nursing care carries with it some well-recognized conceptual problems, for example, are we using a strong or weak conception? Once the meaning of a concept is in doubt, it might fail to develop a shared meaning. Then further problems can arise in nursing practice, for example, even if agreement is reached on the meaning of holistic nursing practice and how it can be evaluated, how might we know whether two nurses are each practising holistic nursing care? Nevertheless, at the core of the notion of 'holism' lies a plausible and attractive idea: that patients are not just physical entities. In order to meet a contemporary definition of a 'good' nurse, it is necessary to care for the 'whole' person, including physical, psychological, spiritual, and social needs.

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# CHAPTER 3 – THE VIRTUES IN GENERAL ETHICS

## Introduction

The importance of interpersonal responses in nursing practice has been established. It is also clear that one needs to reflect about the role of a nurse and the traits that nurses ought to demonstrate if 'high' quality nursing care is to be delivered.

In the previous Chapter, I began to discuss 'the virtues'. In this Chapter, I turn to general ethics and take this discussion further. I confine discussion of the virtues to general ethics so that some of the theoretical foundations for the remainder of this thesis can be laid. I focus on the place of the virtues in the history of philosophy, ask what a virtue and vice are, examine why the virtues are valuable in peoples' lives, and discuss an advantage and disadvantage of the virtue-based approach to morality.

### On the idea of one's life faring well

Is it plausible to suggest that autonomous persons with decision-making capacity usually wish that their needs are met and interests promoted? Based solely on personal experience, I believe that this is true. Physical needs must be met or illness would occur. People want their emotional and social needs to be met so that their lives possess a certain level of quality that that person is content with; generally lives are enriched and fare well if needs are met. Need more be said about the notion of a life faring well? In this thesis, one's life goes well if needs are met and interests promoted; judgments concerning this state of affairs are to be made by the person concerned. For instance, if I wanted to form good long lasting friendships with other people and for one reason or another this did not happen, then my life – in terms of this one aim - has not gone or fared well; at least it has fared less well than I hoped it would. Or suppose that I really wanted to become financially wealthy and despite my best efforts this did not occur. Then I might judge that my life has not fared well, again at least in terms of this

one (important) aim. Other aims (or life plans) that people set for themselves include wanting to achieve certain, perhaps high, career goals, wanting to travel the world, wanting to develop personal qualities such as self-confidence, and wanting to be healthy. Whenever these objectives are not successfully met and thus there is a gulf between reality and desires, then one might judge that one's life has not fared as well as one had hoped.

**The virtues in the history of philosophy**

Ancient Greek philosophy provides an early account of the role of the virtues in human lives, understood in terms of human nature, the good life for humans, and the notion of human flourishing.[1]

However, when examining Plato and Aristotle's ethics it should be remembered that ethics, for the ancient Greeks, was bound up with politics. The primary focus was on forming and maintaining a just state. Thus the idea of virtue was understood in terms of how it could help men to protect their states.

The central question posed by Aristotle in the *Nicomachean Ethics* is 'what is the good life for man?' Crudely, his response was living the life of virtue according to reason and desires (I discuss Aristotle's ethics in more detail in Chapter 5). This account changed with the monotheism of Christianity; the virtues were now neglected and God was seen as a lawgiver. According to God, righteous living meant being obedient to the divine commandments. The Christian thinker, St. Augustine, distrusted reason. Instead he held that to be morally good one needed to subordinate oneself to the will of God. Thus the theological virtues – faith, hope, charity, and obedience – held a central place in Divine Law. In the medieval period, Aquinas devoted a large part of *Summa Theologiae*[2] to the virtues. The Enlightenment saw the rise of Reason, and a return to

secular ethics. In the 17th century, Hobbes[3] believed that glory and profit were the only human motives.[4] However, in Hume the virtues of sympathy and benevolence were at the core of his moral theory. And although Kant is held to be one of the founders of deontology, he actually argued in *The Doctrine of Virtue*[5] that persons had strict (perfect) duties to cultivate the virtues.[6] Kant's Moral Law replaced Divine Law. The question posed by moral philosophers became 'what is the right thing to do?' The aim of the Moral Law was to produce a system of rules so that individuals, who were obliged to follow these rules, could know which actions were right and wrong. Thus, modern moral philosophers, as a result of going in a different direction from the Greeks, developed theories of obligation, for example, Kantianism and utilitarianism, instead of theories of virtue. While this account is brief and incomplete - it treats over 3000 years of human history in less than a page - it is nevertheless accurate and representative of the development of obligation-based moral theories.[7]

## What is a virtue?

### Aristotle on virtue

In Book Two of *The Nicomachean Ethics* Aristotle stated that the soul consists of three kinds of things: passions, faculties, and states of character. Aristotle believed virtue is neither passions nor faculties; "all that remains is that they [the virtues] should be *states of character*".[8] He distinguished between moral and intellectual virtue. The latter were taught through instruction and were split into scientific knowledge (*episteme*), intelligence (*nous*), technical skill (*techne*), wisdom (*sophia*), and practical wisdom (*phronesis*). Conversely, moral virtue was acquired through exercising the virtue, "moral virtue comes about as a result of habit".[9] The emphasis is on the word 'habitual'. Taking honesty as an example, someone who is honest on *certain* occasions – perhaps when it is convenient to be so - does not posses the virtue of honesty. On the Aristotelian view, the honest person is *always* honest. For Aristotle, the actions of a virtuous person spring from a steady unchangeable character.

The use of 'virtue' rather than 'the virtues' reflects Aristotle's interpretation of 'virtue' as a 'state of character'. However, Aristotle is inconsistent because he also uses the plural, that is, *states* of character. Thus clarity is lacking. It seems to me that the ancient Greeks understood virtue and the virtues as two different but related things. First, 'virtue' as a complex mental state and second, 'the virtues' as morally excellent character traits or dispositions needed to live good lives.

I discuss Aristotle's ethics in more depth in Chapter 5. For now, I shall just say that Aristotle believed that the virtuous person would fare better in life than the non-virtuous person.

**Are the virtues types of knowledge?**

Plato in the *Meno*[10] discusses the idea that virtue is knowledge. In ancient Greece, to possess knowledge was to be virtuous; in other words, knowledge of the good life *made* a man good. But, like Aristotle, Plato held that only certain people – in fact, only Athenian gentlemen, women were excluded – could achieve the status of virtue.

I shall discuss the idea that virtue is knowledge in more detail. Whilst I have not yet examined the nature of specific virtues, I cite examples to make this debate more fruitful.

One dictionary definition of the word 'knowledge' is "awareness or familiarity gained by experience (of a person, fact, or thing)".[11] Are virtues such as courage and justice ultimately types of knowledge? In what sense could a virtue such as compassion be knowledge? It is clear that contradictions spring from the claim that virtue is knowledge. For instance, Sam displays courage when she rescues the toddler from the path of the oncoming car. During the rescue, Sam's leg is injured. In the light of her injury, it might be thought that Sam lacked wisdom. On one level, this appears

plausible. If this is accepted, then Sam possessed *and* lacked virtue. However, in trying to save the child Sam was aware that she might get hurt. Action in the face of possible danger partly characterizes courage. It is not easy to save a child's life when serious harm to self might occur. Realizing the potential for harm makes the deed even more admirable. Afterwards Sam might act with great humility, responding to others' compliments with 'Oh, I didn't have time to think.... anyone would have done the same... I'm not courageous'. But underestimating the measure of her act and reflecting about the deed with modesty are themselves admirable personal qualities.

Consider justice as a virtue. To act justly one needs to know what it means to be just. In this sense, the notion of having knowledge is a necessary condition of being a virtuous, in this example, just, person. Is there a connection between having knowledge of a specific virtue and being virtuous, that is, exercising that virtue? Does such a knowledge base encourage and promote self-reflection and a deeper level of thinking? It is possible for someone to have a broad and deep knowledge of, for example, justice as a virtue and yet not be a just person; this can apply to any of the virtues. The reverse is true too: someone might have an idea of what it means to be a just person and live according to such an idea, yet this person has never once read any literature on justice as a virtue. These questions remind me of some students' assumptions and preconceptions. During teaching and learning sessions, it has transpired that some students assume that having knowledge of ethics means that I must be a moral person. Possessing knowledge of any discipline is something that can be admired. However, it is not true to suggest that having a considerable theoretical knowledge base in ethics somehow results in moral behaviour; it is no easier for me to be moral than it is for others, including students of nursing who are beginning to learn about the complexities of ethics.

Perhaps the claim that virtue is knowledge should be understood in terms of having wisdom or being a wise person. It is commonly supposed that people become wise through experience. But experiences are personal. Furthermore, subjective interpretation lies at the core of understanding and learning from experiences. It is possible for two people to undergo the same experience, but (even if this is actually possible) they will perceive elements of the situation differently and interpret the situation in different ways. As a result these two people will focus on different things and their learning will be dissimilar. So merely having many experiences does not necessarily make someone wise. Moreover, the claim 'the wise agent just knows what to do' sounds to me as though it is grounded in intuition. I reject the claim that intuition can tell people what to do. Like Hursthouse,[12] I hold that intuition is a deeply unsatisfactory notion, because it lacks any firm grounding. I reject the use of the singular 'virtue', because I am referring to character *traits*. Therefore, I cannot accept the idea that 'virtue' is knowledge in the formal sense of the word. I accept however, that acting virtuously requires people to possess forms of knowledge gained through having familiarity and comprehension of previous experiences.

**The contemporary meaning of the term 'virtue'**

Two uses of the word 'virtue' can be readily distinguished. First, when it is used as a noun, virtue can mean 'advantages' or 'strengths' as in 'this system has the following virtues..' Second, 'virtuous' may be used as an adjective in relation to persons, for example, 'Carol is a virtuous girl'. Both usages provide positive and complimentary descriptions, which imply praiseworthiness; 'virtue' is not used in a negative sense. Even at this relatively early stage, it can be seen that the Greek idea of virtue does differ somewhat from contemporary accounts.

**Assumptions about virtues and goodness**

At this point, I need to focus on one of the criticisms of the virtues and the virtue-based approach to morality. In short, this is that there is an assumption that the virtues are good. This assumption about the goodness of the virtues leads to a circular argument. For example, that by being virtuous – exercising virtues such as honesty – one will be a good person and lead a good life, but to be 'good' one needs to be virtuous. However, where does the belief that the virtues *are* good character traits originate? What are some of the reasons for this assumption? Whose authority grounds this belief? This assumption needs acknowledgement and investigation.

The term 'virtue' derives from the ancient Greek word '*arête*' meaning excellences of character.[13] Aristotle focused on certain virtues, for example, wisdom, justice, courage, and temperance. Since ancient Greece, the use of the term 'virtue' has been used to mean excellences of character or good traits of character. It appears that this usage has been widely accepted and not attracted criticism. The moral philosophies of Socrates, Plato and most influentially perhaps, Aristotle, provide some degree of authority in which to ground this belief.

There appears to be a relationship between the idea that knowledge and virtue are synonymous and the view that many people hold today concerning the value of knowledge *per se*. For many people, the idea of 'knowledge', of being 'knowledgeable' and of 'knowing' something is seen as valuable; it is often thought that having knowledge is a good thing and that it is unfortunate if one lacks knowledge. The relationship between possessing knowledge and being autonomous, self-determining, and taking control of one's life is well established, especially in health care ethics. For example, the notion of making informed decisions after professionals have provided sufficient knowledge of the aims, risks, and benefits of treatments. Of course, it is important to think about the purpose and uses of knowledge and therefore whether

knowledge is intrinsically or instrumentally valuable. For instance, is knowledge valuable for its own sake or for what it might be used for and the effects it might have on human life? It seems to me that many people admire those with knowledge and it appears that some people envy those who possess a rich knowledge of a certain subject. I shall accept the claim that most people believe knowledge is a good thing and therefore has value. If this is true, then this might lead to the belief that the virtues, seen in terms of character traits, are also *a* good and should therefore be cultivated and exercised, so that the possessor can *show* his or her goodness.

**Morality, ethics and the moral life**

Morality is concerned with the origins, development, and application of one's values, beliefs, and customs. Ethics or moral philosophy is the philosophical discipline that examines morality. There are two major questions that moral philosophers pose: what is the right thing to do? And what is it to be a good person? In response to the first question, the nature and role of moral principles, rights, responsibilities, and obligations are critically examined. The second question concerns moral character. In a specific attempt to respond to this area of human life, the virtues have been understood throughout the history of virtue ethics and including its contemporary conception, in terms of traits of character that display moral excellence, deserve admiration and praise from others, and help both the possessor and others to lead *morally* good lives. Ethics is concerned with examining good lives from a *moral* point of view by, in part, considering the question of how persons can be good and to a large degree, thinking about how humans can live together harmoniously. But, of course, it is possible for a person to have a good life, based on a conception of personal well-being, that is markedly different from moral goodness. For example, choosing to lead an egoistical life, one of self-interest, which might be achievable through being a cheat, liar and thoroughly dishonest. These vices conjure up images of a person whom I believe most of us would wish to avoid; I would not wish to form a friendship with someone who

behaved in these ways. Conversely, if one overheard a colleague talking about someone they had just met, using words like 'honest', 'fair', 'sensitive' and 'patient', I believe that many people would think that this person sounds 'nice' and is perhaps someone worth getting to know. Judgments about people whom one has not yet met concern several factors including one's moral values, moral education, and the action guidance one gets from thinking about specific virtue and vice terms; some of these issues will be examined in the course of this thesis. It does, however, appear plausible to connect an understanding of individual character traits called virtues, other example are kindness, tolerance, and respectfulness, with the sorts of lives many people believe humans ought to live. Thus, on the one hand, it is important to acknowledge the assumption about the meaning of 'good' and the circularity of argument. However, on the other hand, this assumption is based upon plausible moral reasons that aim to provide a convincing account of how humans can lead morally good lives, flourish as individuals, and live well together. It seems to me that this explanation of the goodness of the virtues in terms of living a moral life relates well to the views expressed through 'common sense' morality, that is, the view that many ordinary people (I mean, non-philosophers) have about the sorts of personal qualities people ought to display to lead a morally good life.

**Virtues or vices?**

However, Aristotle's conception fails to distinguish virtues from vices because the latter are also character traits manifested in habitual action. Pincoffs provides one account of how to resolve this problem. He claims that the virtues and vices should be thought of as qualities that persons think about in deciding whether someone should be avoided or sought. He writes

> Some sorts of person we prefer; others we avoid...The properties on our list can serve as reasons for preference or avoidance. [14]

Regarding the vices, most people would probably wish to avoid meeting other people who are, for instance, cruel, callous, mean, or dishonest. These kinds of negative character traits are not admirable either in us or in others. People who cultivate and exercise the vices should not be worthy of praise or admiration.

**Is it possible to list the virtues?**

There are numerous moral virtues. It is difficult to be accurate about the exact number. If one were to imagine a positive adjective that can be used to describe someone's character, then it is probably a virtue, for example, an *honest* person, a *kind* person, a *patient* person, and a *tolerant* person. The literature that I have reviewed does not speculate on the number of virtues imaginable. It is the same for alternative moral theories and approaches; for example, there is no preoccupation with the 'total' number of moral principles of use in health care ethics. Particulars of situations and context are important in fostering the cultivation and exercise of the virtues. Therefore, even if one wished to, it would be extremely difficult and time consuming to identify every conceivable positive personal quality that might be considered a virtue; the lives that contemporary humans live are so complicated and multi-faceted to render this aim futile.

The virtues are sometimes sub-divided in an attempt, I think, to make these traits easier to remember, understand and apply in concrete situations. For example, compassion, honesty, benevolence, and patience are among the so-called other-regarding virtues. Justice and fairness are classed as social or civic virtues. Other, less widely acknowledged, virtues include assertiveness, tolerance, and temperance. The latter do not appear to be categorised.

Rachels provides a list of common virtues.[15] However, one needs to note that a list merely functions to provide examples of virtues, and as a result such lists will be incomplete. If someone delivered a list of 25 moral virtues and argued that it was the complete definitive list, how might I respond? I might reply 'oh, this list is quite comprehensive, but what about respectfulness..... or trustworthiness?' An amended list of 27 (the 25 on the list, plus respectfulness and trustworthiness) moral virtues might then result. But later on someone else gazes at the list and says 'Oh, it's a good list but what about courage?' And this process would continue. It is difficult to argue that a list of moral virtues is complete; amendments to the list will result from other people thinking hard about the moral character of persons, situations faced in life, and how to lead good moral lives. Specific virtues are required in different situations depending upon several factors (to be described soon) and upon reflection of these factors, 'new' virtues will spring to mind. I would disagree with those who might allege that this inability to produce a complete list of virtues is objectionable. Instead it serves to remind us just how complex human lives can be. Furthermore, it ensures that rigorous thinking about different kinds of lives and deep reflection regarding possible candidates for the status of virtues is not only possible, but remains an exercise in human intellect that should be encouraged and admired. It seems to me that believing that a list of virtues is complete amounts to wasted opportunities for philosophizing about the moral character and moral lives of persons.

## What might determine important virtues?

### Virtues and roles

Peoples' lives consist of many diverse roles and ends. It appears sensible to think that different virtues will be necessary and relevant depending upon the nature of these roles and ends. Rachels'[16] examples are an auto mechanic and a teacher. He believes that an auto mechanic should be honest, conscientious, and skilful, while a teacher should be articulate, patient, and knowledgeable. Another example might help. Imagine

a lawyer whom I wish to act on my behalf. I would like her to be intelligent, articulate, and courageous. By exercising these traits she could act well as my advocate and promote and safeguard my legal rights. The inculcation of the virtues depends upon one's roles.

**Is a single set of virtues desirable for all persons?**

Given the above it would seem that the answer here is in the negative. Because people differ and there are so many contrasting roles and responsibilities, many different virtues are important to live morally good lives. But is it useful to think in terms of 'the good person'? This might imply that everyone evolves from the same mould. Nietzsche for one challenged this claim. In rejecting the assumption that only one form of human goodness exists, he said

> How naïve it is altogether to say: "Man *ought* to be such-and-such!" Reality shows us an enchanting wealth of types, the abundance of a lavish play change of forms – and some wretched loafer of a moralist comments: "No! Man ought to be different". He even knows what man should be like, this wretched bigot and prig: he paints himself on the wall and exclaims, "Ecce Homo!"[17]

Nietzsche is not readily recognized as a philosopher interested in the virtues. However, the above quotation illustrates that he believed that many forms of human goodness exist. On his view, the virtues would differ from person to person depending on one's personality and professional and social roles. But historical eras need to be taken into account too, as norms of behavior are interpreted within the context of history. For example, qualities in two women, in different periods of history, may both in different ways be virtuous and admirable. According to Rachels,

> A Victorian woman who would never expose a knee in public and a modern woman on a bathing-beach have different standards of modesty. And yet all may be admirable in their own ways.[18]

**Do the virtues differ within different societies?**

The short response is affirmative. But a lot depends on the kinds of practices[19], institutions, and values sustained (and deemed permissible) in particular societies. In other words, the sort of human life one is *able* to live. Since the character traits required to successfully fulfil professional and social roles differ, the virtues required to live successfully will differ too. Different societies play an important part in grounding and influencing the cultivation of virtues. Therefore one question worth asking is, 'do all people need some virtues irrespective of the era?' On this, Aristotle remarked

> One may observe in one's travels to distant countries the feelings of recognition and affiliation that link every human being to every other human being.[20]

Aristotle is here suggesting the universality of at least some virtues. Certain essential human needs, for example, physiological needs such as respiration, eating, and drinking remain the same irrespective of one's culture; human physiology does not depend on culture. Are moral virtues important in satisfying human needs? With regard to physiological needs, one response is to suggest that, directly at least, moral virtues prove of limited use. However, in satisfying non-physical needs, such as, the need to form friendships and the need for self-preservation, it is plausible to believe that some moral virtues, for example, honesty, loyalty, and courage, are, irrespective of cultural background, important in meeting these needs.

**What is a virtue? Revisited.**

I now return to the question, what is a virtue? According to contemporary moral philosophers[21], moral virtues are character traits that dispose one, its possessor, to habitually act, think, and feel in certain ways. For example, Rachels believes that a virtue is "a trait of character, manifested in habitual action that it is good for a person to have"[22]. The moral virtues are those that it is good for everyone to have.

The virtues form part of one's character; they are an internal part of one's identify. Moral obligations and principles can be viewed as being external to the person, as these social constructs are imposed on people from the outside world; for example, professional obligations from the Nursing and Midwifery Council[23] and legal obligations derived from statutory and common law. These externally motivated obligations are therefore not necessarily compatible with the kind of person one is. I mentioned above that the virtues dispose people to act, think, and feel in certain ways. To be more specific, following Aristotle, the virtues are *excellences* of character. The moral virtues are morally excellent character traits or dispositions. Cultivating and exercising the moral virtues is instrumental in being able to lead morally good lives. Exercising the moral virtues tends to help people fare well in life and this helps others fare well too. But I repeat that I am talking about faring well in moral terms. Being dishonest might help one to lead a good life, but not a morally good life. Inculcating the moral virtues will help one to act, think, and feel in morally excellent ways.

I would add, however, that the virtues should be regarded as morally admirable traits of character deserving of one's admiration.[24] People who exercise moral virtues deserve to be praised and admired because of the moral excellence of their deeds, thoughts, and feelings. This conception of a moral virtue is adopted throughout the remainder of this thesis. Then, in chapter 8, I amend this conception in the light of MacIntyre's thesis about practices and the internal goods.

## Why are the virtues valuable?

### The example of honesty

Why should the virtues be valued? I have stated that the virtues are morally excellent character traits, which help people to lead morally good lives and deserve praise and admiration from others; it seems to me that the question should be 'what reasons are there for *not* valuing these traits?' Of course another response is to claim that valuing a

virtue will depend upon the particular virtue in question. What is so good about, for example, honesty? If I am an honest person, if I exercise the virtue of honesty – that is, do honest deeds and think and feel in honest ways – then this will help me form and maintain good mutually beneficial friendships. Of course, the assumption here is that the honest person would not be selfish and disloyal. In other words, if I inculcated one virtue – in this case honesty – I would probably inculcate other virtues or at least refrain from inculcating the vices. However, this is far from straightforward. This view is based on the idea that the person who inculcates the virtue of honesty does so not on a whim, but only after deep prolonged introspection and deliberation. This person desires to become virtuous, because she is aware of how exercising the virtues can positively affect the flourishing of other people and oneself. Therefore it would be counter-productive and self-defeating to inculcate one or more virtues only then to inculcate one or more vices.

**The example of kindness**

Regarding the value of the virtues, another example may help. Robert is a charity worker in Africa helping to care for people who are sick and dying. He is kind towards others. He believes that being kind is crucial to his role because he can see that those whom he cares about are helped through his acts and feelings of kindness; perhaps there is also a quality or feature of his kindness that others can *feel.* Robert works consistently hard to be kind towards other people. By acting, thinking, and feeling kindly Robert does well in his chosen role and others are helped, in part, through his kindness. He derives a great deal of satisfaction from his work and his kindness does not go unnoticed. Indeed so many people tell Robert's leader about his kindness that he is soon offered promotion. Thus, even though Robert may not have striven for promotion, this is offered to him; of course he may turn a new post down because he does not wish to leave his charity work in Africa, but that is a separate matter. This example is limited to one other-regarding virtue, namely, kindness and it could be

accused of being a trite oversimplification of the truth. However, it serves to show how the virtues are important to humans; how in this scenario Robert's kindness helped others to fare better in life and how it helped him to do well too. Exercising the moral virtues, especially other-regarding virtues such as kindness, is particularly important when working with people who are helpless and vulnerable (this is one of the reasons why I examined these feelings in the previous Chapter).

**Communities and the virtues**

Thinking generally about why[25] it is good to cultivate the virtues, it is true to say that humans are typically (though not always) rational and social creatures, who live in communities. Humans interact with one another and communicate in different ways. Communities are composed of individuals who might live alone or form families. To interact with each other successfully, the virtues of honesty, justice, and loyalty – to name only 3 – are important. This is plausible as long as humans wish to get on well together. What might happen if people instead exercised the vices of dishonesty, injustice, and disloyalty? Using dishonesty as an example, dishonesty would adversely affect one's ability to trust another person. Dishonesty and a lack of trust might mean that more people lived in isolation or in smaller groups. Eventually more communities would fragment and disintegrate. Close relationships, including marriage, would be unsustainable. Imagine the effects on communities if dishonesty was joined by injustice and disloyalty? As noted earlier, it is clear that people have different needs and interests; one's roles and responsibilities differ too. Many different virtues will be necessary to successfully achieve these ends. The virtues are therefore valuable because in meeting these ends they help humans lead morally good lives.

**The 'virtues' of chastity and temperance: more difficult examples**

However, the virtues of honesty and kindness are clear-cut examples. These traits are usually seen by people as positive qualities and as such, prove non-problematic when examining the notion of ascribing value. If one asked 'name two traits of character or personal qualities that are associated with being a good person?' I imagine that both honesty and kindness would appear high up on the list of responses. But when the virtue in question relates to behaviour not widely valued, then the virtue itself will require further scrutinizing. According to Benn, chastity is such a 'virtue'. He asks, "What is so admirable about chastity?"[26] Without further examination, Benn is sceptical that appealing to this virtue can provide plausible reasons for sexual restraint. Another example is temperance, which was a trait highly valued by Aristotle. Some people see little or no reason to moderate their behaviour, for example, refusing to curtail their alcohol consumption or being unwilling to reduce their dietary intake. This sort of discussion easily leads to more general disagreement regarding the question, which traits of character are virtues and which are not?' A character trait is a moral virtue in my view if it meets the conception described earlier in this Chapter. This is an important question, however, because the charge of moral relativism looms large if this question is not satisfactorily resolved.

**Lacking virtue and showing the vices**

It is interesting to consider the nature of virtues by thinking about what might happen if one lacked the virtue in question. For example, would Robert fare as well if he lacked kindness? Would those people he cared for have benefited in quite the same way? Would his work have been noticed? Or similarly would a primary school teacher succeed in her role – fare well - if she lacked patience with the children she taught? How does exercising the vices – for instance, dishonesty, cruelty, and unfairness – affect the ability of other people to lead a morally good life? The inculcation of the virtues will not be deemed important or valuable if a person has no intention of leading

a morally good life. But for those people who do set themselves this challenge, the virtues ought to be taken seriously and take centre stage.

## Advantages of the virtue-based approach to morality

In Chapter 5, I examine the rich and plausible account of moral motivation and moral character that virtue ethics (the moral theory that make the virtues central to morality) provides. I develop an account of the virtue-based approach to moral decision-making in nursing practice in Chapter 7. I limit this section to examining the moral force of virtue and vice terms.

### Action guidance from virtue and vice terms

Moral theories usually aim to provide action-guidance for persons. In moral dilemmas and situations that are morally tense, a moral theory will help a person to know what to do. With regard to action-guidance, Hursthouse[27] believes that it is important to consider the broad range of vice terms to be found within the vocabulary of the virtues and vices. Indeed, the list of virtues in comparison is relatively short. Not only is the list of vices long, these terms are also remarkably useful to one's conduct. Virtue terms, such as 'honest', 'fair', 'kind', and 'patient' and the opposite vice terms, for example, 'dishonest', unfair, 'unkind' (or 'cruel'), and impatience, according to Hursthouse, provide greater explanatory force for people compared with obligations and deontic (duty-based) terms (I discuss this in more depth in relation to nurses in Chapter 7). Anscombe heavily influences Hursthouse's view on this. According to Anscombe, instead of using deontic terms, she believes that "It would be a great improvement if, instead of "morally wrong" one always named a genus such as "untruthful", "unchaste", "unjust"...the answer would sometimes be clear at once".[28] Hursthouse believes that people can gain a lot of "invaluable action guidance..from avoiding courses of action that are irresponsible, feckless..harsh..feeble..self-indulgent." [29] In other words, one can discover a lot of action guidance and gain an insight into what to do by thinking

hard about the virtue and vice terms and the sorts of deeds expected of someone who exercises specific virtues or vices.

Suppose I wonder whether I can justify lying to Adam. I can get a clearer idea of how I ought to act by considering whether the range of behaviours open to me are honest, fair, or hurtful, rather than by asking whether the behaviours are right, wrong, ethical or unethical. How much action guidance is forthcoming from the prescription, 'do what is ethical'? How can the latter phrase help me especially when I find myself in a really difficult situation, saturated with moral tensions, and I simply do not know what to do? Benn suggests that virtue and vice terms such as kind and dishonest respectively carry 'rhetorical resonance', which can positively affect one's behaviour. In other words, upon hearing 'you should do what the kind agent would do' I begin to get a sense of the range of acts, thoughts, and feelings that kind persons are known for. Then upon deeper thinking I become increasingly aware of the meaning of 'being kind'. Benn believes that "words like *dishonest* play a more central role in everyday moral talk than words like *wrong*".[30] I agree with this claim. As a child one hears these sorts of virtue and vice terms from parents and other adults on a regular basis. I believe that as one develops into adulthood, words such as 'fair' and 'kind' are replaced with the language of obligations, especially the central concepts of 'right' and 'wrong' action. Benn holds that the idea of right and wrong action should not be dispensed with. However, the use of virtue and vice terms can prove to be really helpful in an attempt to gain action guidance and also when people wish to evaluate the actions of others.

**Problems with the virtues**

Regarding the virtue-based approach, one serious problem is conflicts between virtues and how these can be resolved. In a given situation, it will usually be difficult to know how to respond to someone. How should I behave in this situation? Should I tell my friend the truth, be honest to her, and risk hurting her feelings? Or should I be kind to

her, aim to protect her feelings, but deceive and perhaps lie to her in the process? This example involves making a stark choice between being kind or being honest, when it is thought that one cannot be both. I discuss conflicts between the virtues in Chapters 5, 7 and 10. In this section, I briefly note the problem of identifying the virtues.

**Identifying the virtues**[31]

Disagreement exists on which character traits are virtues. For example, one person compiling a list of virtues might believe that honesty, patience, and tolerance are virtues. Another person may disagree, instead favouring compassion and integrity. However, I am sceptical that a person who advocates the virtuous approach would, on the one hand, defend honesty and on the other hand reject compassion. A virtue on my view is a character trait, habitually performed, which disposes one to act, think, and feel in morally excellent ways. Those who exercise the virtues deserve praise and admiration. The fact that there are so many plausible virtues is not sufficient reason to claim that these traits are not *all* virtues.

Instead of the above claim, perhaps the claim is that there *are* only *several* virtues. This view opposes the claim that I made earlier in this Chapter that numerous different virtues exist. For instance, in the above, the claim is that *only* honesty, patience, and tolerance *are* virtues, but not compassion and integrity. I reject this claim, however. It should be clear by now that the moral life cannot be exhausted by reference to three character traits. One who suggests that there are only *three* real virtues (or indeed just one or two) needs to respond to several questions, which centre on context and particulars of different situations. For example, how can humans live morally good lives without being *just*? In other words, without the virtue of justice is it possible to be morally good and if so, how? Surely if the response to this question is affirmative, then one must be committed to a view of moral goodness that excludes the virtue of being a just and fair person.

**The moral status of the virtues**

In this final section, I discuss in general terms the question, "what status should the moral virtues be accorded?" It is an important question and one that is sometimes posed by the critics of the virtue-based approach.

Are persons obliged to cultivate the virtues in a maximising, utilitarian sense? Do persons have a strict positive duty to cultivate the virtues as Kant argued? [32] Or instead, is it merely *nice* for people to cultivate the virtues?

Benn gives one response to the question of ascribing moral status to the virtues. He asks 'could the virtues be human needs?' Benn writes

> We all need the virtues – that is, we need to possess them ourselves, rather than merely profit from the possession of them by others.[33]

He holds that the virtues "are needed for the satisfactory fulfilment of the activities in which we characteristically engage. [34]

What does it mean to say that one thing is needed for something else? Benn[35] replies that there might be a simple means-end relation. Consider Black, a lecturer. He wants to be well known and respected among his peers. He realizes that he needs to work hard to realize his aim. But while Black *does* work hard, he sees no intrinsic value in working hard, in being industrious. Indeed as Benn remarks, "he may prefer, other things being equal, to do as little as possible".[36] Black might not work as hard if he was certain that he would still become respected and well known.

Aristotle did not talk in terms of virtues as needs. But this is to be expected since in ancient Greece, the notion of human needs – physical, spiritual, and psychological – had yet to be intellectualized. It remains true however to claim that one *needs* the virtues on Aristotle's view in order to fare well and flourish. If people fail to cultivate the

virtues, then in moral terms people would tend not to fare as well as the virtuous. Clearly, however, if one was simply not interested in being a moral person or leading a morally good life, then exercising the vices can result in a good life, not in terms of moral goodness, but perhaps in terms of financial wealth, power, and status. I discuss Aristotle's ethics in more detail in Chapter 5.

But the virtues are not needs in the same sense that, for example, breathing, eating, and drinking, are. However, if one rejects (a) one is obliged to cultivate the virtues and (b) the virtues are human needs, what other candidates remain in which to ground the virtues? It seems too trivial to claim that Robert, the kind charity worker, ought to cultivate kindness because this would be *nice* for him and *nice* for others. This claim is weak. Importantly, it is too weak and insubstantial to motivate people to inculcate the moral virtues in the first place; especially given the fact that inculcating the virtues is a very demanding and challenging process. Indeed this is surely one good reason why so many people do not bother.

In relation to Benn's 'virtues as needs' thesis, Robert might believe that to fare well he needs to cultivate kindness. Or the scholar might think he needs to cultivate courage to fare well. For example, Robert might say 'I *need* to be kind to fare well and benefit those whom I care about, because if I don't then my life will not go as well and those in my care will not benefit to the same degree'. Likewise, the scholar can say 'I *need* to be courageous and fight for those ideas I believe in, if not I will fare less well and others will benefit less from my work'. Regarding some essential physical needs, if one is deprived of nutrition and hydration then one will not fare well; one will suffer from malnutrition and dehydration. I believe that the virtues can plausibly be regarded as *moral* needs, which are crucial to enabling people to lead morally good lives.

## Conclusions

My conception of a virtue has been outlined. It is plausible to claim that persons need to inculcate the virtues if they wish to fare well in life in terms of moral goodness. Advantages of the virtue-based approach to morality include the rich and highly textured degree of action guidance derivable from the virtue and vice terms. Problems with this approach, however, include conflicts between the virtues (which shall be discussed in detail later in Chapters 5, 7 and 10) and the supposed difficulty in identifying which traits are virtues.

In the next chapter, I critically examine the role of moral obligations in morality and identify some of the merits and disadvantages of consequentialism and deontology.

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[6] Recently, this has motivated work in moral philosophy, which aims to forge links between moral obligations and the virtues.

[7] This is drawn from, J. Rachels, *The Elements of Moral Philosophy*, 3rd ed. (New York: McGraw-Hill, 1999), pp. 175-176.

[8] Aristotle, *The Nicomachean Ethics*, trans. D. Ross, revised J., L. Ackrill and J., O. Urmson (Oxford: Oxford University Press, 1980), Bk. 2, 5, 1106a17, p.36.

[9] Aristotle, *The Nicomachean Ethics*, trans. D. Ross, revised J., L. Ackrill and J., O. Urmson, Bk. 2, 1, 1103a33, p.28.

[10] Plato, "Meno" trans. W., K., C. Guthrie in *Protagoras and Meno* (London: Penguin Books, 1956), pp. 101-157.

[11] "Knowledge" in *Oxford Compact English Dictionary* ed. D. Thompson (Oxford: Oxford University Press, 1996), p. 549.

[12] R. Hursthouse, *On Virtue Ethics* (Oxford: Oxford University Press, 1999).

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[15] J. Rachels, *The Elements of Moral Philosophy*, 3rd ed. (New York: McGraw-Hill, 1999), p. 178.

[16] J. Rachels, *The Elements of Moral Philosophy*, p.178.

[17] F. Nietzsche, *Beyond Good and Evil*, trans. Walter Kaufmann (New York: Vintage Books, 1966), part 5.

[18] Rachels, *The Elements of Moral Philosophy*, p.186.

[19] I return to discuss the idea of practices in Chapters 8 and 9 in which I argue for a MacIntyrian practice-based account of the virtues in nursing.

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[21] For example: R. Hursthouse, *On Virtue Ethics* (Oxford: Oxford University Press, 1999); P. Benn, *Ethics* (London: UCL Press Ltd., 1998); C. Swanton, "Virtue Ethics and Satisficing Rationality" in *Virtue Ethics – A Critical Reader* ed. D. Statman (Edinburgh: Edinburgh University Press, 1997), pp. 56-81; K. Stohr & C., H. Wellman, "Recent work on Virtue Ethics" *American Philosophical Quarterly* 2002, **39** (1), pp. 49-71.

[22] J. Rachels, *The Elements of Moral Philosophy*, pp. 178.

[23] NMC, *Code of Professional Conduct for Nurses, Midwives and Health Visitors* (London: NMC, 2002).

[24] For example, M. Slote, *From Morality to Virtue* (New York: Oxford University Press, 1992).

[25] I discuss the question of how the virtues can be taught in nursing education in the 'Conclusions'.

[26] P. Benn, *Ethics*, p. 178.

[27] R. Hursthouse, *On Virtue Ethics*

[28] G. E. M. Anscombe, "Modern moral philosophy" eds. R. Crisp & M. Slote in *Virtue Ethics* (Oxford: Oxford University Press, 1997), pp. 26-44, p. 43.

[29] Hursthouse, *On Virtue Ethics*, p. 42.

[30] Benn, *Ethics*, p.174.

[31] In this section I remain consistent and assume that the virtues are *morally* excellent and admirable character traits.

[32] I. Kant, "The Doctrine of Virtue" in *The Metaphysics of Morals* ed. M. Gregor (Cambridge: Cambridge University Press, 1996).

[33] Benn, *Ethics*, p.165.

[34] Benn, *Ethics*, p.179.

[35] Benn, *Ethics*, p.165.

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# CHAPTER 4 - A CRITIQUE OF OBLIGATION-BASED MORAL THEORIES IN GENERAL ETHICS

## Introduction

This chapter is devoted to a critical examination of the role of moral obligations, rules, and principles and their underpinning moral theories in general ethics. I first outline the moral theory known as consequentialism. I focus to a large degree on act-consequentialism, but I also look at rule and indirect forms of consequentialism. Then, deontology is put under the critical spotlight. The broad aim of this chapter is to explicate these obligation-based moral theories and highlight some of their merits. However, I aim to show that the standard objections to these theories outweigh their supposed merits.

### Characterizing obligation-based moral theories.

Obligation-based[1] moral (or ethical[2]) theories can be characterized, fairly accurately, as theories that emphasize the role of moral obligations, moral rules or moral principles[3] in morality. Crudely, obligation-based theorists hold that the role of obligations is crucial in morality; they believe that moral obligations are central to ethics and that moral acts and conduct cannot be achieved without instruction from, at least some, moral obligations. These types of theory claim that persons are obliged to do certain things or behave in certain ways towards others; that one person owes obligations towards another person.[4]

Anscombe believed that modern moral philosophy (she meant, utilitarianism and Kantianism[5]) is bound up with obligation and duty simply because of moral philosophy's historical traditions. In the literature, both moral philosophy and applied ethics, the two predominant types of obligation-based moral theories are

consequentialism (including utilitarianism) and deontology. Both these types of theory focus upon the moral nature of the act itself. Important questions asked by proponents of these theories include, 'what ought I to do?', 'what is the right course of action?', and 'of these two (or more) choices, which one is the best?'

## Consequentialism

Consequentialists can be described as 'forward looking' theorists because they believe that the events after an act are what characterize the morality of the act. Consequentialists argue that what makes right acts right (and wrong acts wrong) are the act's consequences, outcomes, or results.[6] Typically consequentialist theories take the form: "Act x is right if x produces good consequences". Many consequentialists go further and insist that 'good' is insufficient. The consequences of an act have to be the best among a range of possibilities; in other words, what consequentialists call utility, has to be maximized.

### Act-consequentialism

One example of a consequentialist moral theory is act-consequentialism[7], which according to Frey holds "that an act is right if its consequences are at least as good as those of any alternative".[8] This theory is consequentialist because it views the rightness and wrongness of acts in terms of their actual consequences. It is worth noting two criticisms, even at this early point. First, this formulation ignores many other morally important features, for example, intentions and motivations. And second, doubt is raised on the question of how one can know the actual consequences of an act.

However, in response to the charge that it is difficult to know what the consequences of an act will be, two things can be said. It is clearly true to claim that people cannot see into the future and predict the consequences of an act. But experience and wisdom, consequentialists allege, can provide some general guidelines, the sorts of things that

might happen after certain types of acts, for example, if someone is thrown into a lake and cannot swim, then a likely consequence is that that person will get into difficulties and without help might drown. The second point is that all of us, irrespective of our allegiance to a particular moral theory, need to take consequences into account, as Glover claims,

> most of us, whether utilitarians or not, take some account of the likely effects of our actions on people's happiness, and we should all be in a mess if there was no correspondence between trying to make someone happier and succeeding.[9]

I need to stress at this point that I do not object to the term 'consequences' *per se*. Glover is correct in holding that, irrespective of our moral allegiance, one needs to take the consequences of acts into account. However, when this notion is restrictive, excessive and to the detriment of other morally important issues, such as, moral character and moral education, then this is objectionable. Furthermore, when people, including nurses, have a poor, superficial comprehension of 'consequences' and a crude understanding of the meaning and scope of consequentialism, not to mention its problems, then this again is objectionable.

On the relationship between rightness and goodness, Frey believes that act-consequentialism is an example of a welfarist theory because

> rightness is made a function of goodness, and goodness is understood as referring to human welfare.[10]

This suggests that a good act is always a right act. While this is reasonably straightforward, just how is rightness determined? In response to this question, Frey claims that act-consequentialism is

> impersonal and aggregative, in that rightness is determined by considering, impersonally, the increases and diminutions in well-being of all those affected by the act and summing those increases and diminutions across persons.[11]

At least three questions arise regarding the above, which are far from simple to settle. First, how can one go about evaluating or measuring the various 'increases and diminutions in well-being'? 'Well-being'[12] is defined and conceived in different ways, including objective and subjective accounts, thus convergence is problematic. Some might argue that depending on which subjective account is provided, well-being cannot be measured. Second, is it possible to evaluate well-being for 'all those affected by the act'? This is clearly problematic; just how can one *know* which people have been or will be affected by each and every act? Third, act-consequentialism focuses on the impartial nature of morality; indeed impartiality is one of its central tenets. Act-consequentialism considers that the interests of strangers should count equally with those of one's loved ones, but here again problems arise, for example, what does it actually mean to treat someone impersonally and how can one go about this? This charge is commonly described as 'the nearest and dearest objection'. These objections pose serious problems for act-consequentialism as a plausible moral theory.

In addition to act-consequentialism being an example of a welfarist theory, Frey claims that act-consequentialism is also a maximizing theory,

> one concrete formulation of the principle of utility, framed in the light of welfarist considerations, is 'Always maximize net desire-satisfactions.[13]

Desire satisfactions[14] are those kinds of interests, which individuals desire to include as part of their lives. Examples here include good health, relationships with others, wealth, and pastimes. According to the above quote, one should maximize these items on each and every occasion. However, again this is no simple matter and critics point to the difficulty in always maximizing goods and benefits. As a way of avoiding such objections, some theorists have developed 'satisficing' versions of consequentialism, which claim that rather than aiming to maximize interests, people should aim to satisfy their needs and interests; the moral requirement is less stringent, people must aim to

do a considerable amount of good in and for the world.[15] These theorists argue that this version of consequentialism resolves one or more of the standard objections levelled at maximizing forms of consequentialism.

According to maximizing consequentialism, the goal is to maximize human welfare. This begs the question, how should one best go about achieving this? Since Hare's *Moral Thinking*[16], it has been acknowledged that perhaps the best way of maxmizing human welfare overall is to forego aiming to maximize it on each and every occasion. This view, however, contrasts sharply with utiltiarians, such as, Bentham and J. S. Mill. Bentham developed utilitarianism, an extreme form of consequentialism, as a political theory. Mill then adapted it. Utilitarianism, at least in its classical form, holds that maximizing utility for the majority of individuals is the *only* criterion for determining the morality of acts and omissions. It therefore places all of the moral emphasis upon the consequences of an act or omission. Mill states,

> The creed which accepts as the foundation of morals 'utility' or 'the greatest happiness principle' holds that acts are right in proportion as they tend to promote happiness ; wrong as they tend to promote the reverse of happiness. By happiness is intended pleasure and the absence of pain ; by unhappiness, pain and the privation of pleasure.[17]

## Objections to act-consequentialism

Some critical comments regarding act-consequentialism have already been made. I shall now examine in more depth possible objections to act-consequentialism or act-utilitarianism.

### The neglect of moral character

This criticism targets an omission of act-consequentialism and other obligation based moral theories, including deontology. Therefore it needs to be borne in mind

throughout this chapter as it applies to these theories in general. I make this point early in this thesis, as it is crucial to my claims in the remainder of the thesis.

The notion of adequacy in relation to moral theories helps determine one's preferences and views about the plausibility of particular moral theories. For example, it partly explains why some thinkers prefer obligation based moral theories to character based ethics. Rachels' believes that an adequate moral theory

> must provide an understanding of moral character; and
> second, that modern moral philosophy has failed to do this. [18]

I accept this claim without reservation; indeed this claim motivates much of this thesis. The reason why I believe moral theories must provide a satisfactory account of moral character is because I view ethics as a discipline that has at its core a concern for how people respond to the needs and interests of others and how people get on in life. For example, do they fare well or badly? Without a plausible account of one's moral character - the kind of person one is, demonstrable by the inculcation of character traits, both virtues and vices, and one's motives for action – this particular debate regarding morality, the virtues, and human responsiveness will be stifled. I discuss moral character in relation to general ethics in more detail in Chapter 5 and in relation to nursing practice in Chapters 7 and 9.

**Anti-theory and the assumption that moral dilemmas are resolvable**

Act-consequentialism focuses, restrictively so, on the notions of 'right action' and 'morally right action' (this also applies to act-utilitarianism and deontology). According to these moral theories, 'ethics' is often conceived as a search for 'right' and 'wrong' answers to moral dilemmas. The aims of moral theories are not clear-cut; indeed there is disagreement on this in the literature. Questions include: what is it that moral theories should do? What do persons want and expect from moral theories? Williams[19], for example, believes that it is unrealistic to expect one, or even a hybrid,

moral theory to resolve moral problems and dilemmas. This is because the moral life is too richly textured and complex for this to be possible. Obligation-based moral theories, as noted, have at their core the desire to provide action guidance and develop some kind of decision procedure for settling moral dilemmas. These theories fail to account for other aspects of the moral life that are so obviously important and yet these aspects are either completely ignored or neglected in large part by consequentialism and deontology. Williams, is, I believe, known by others as an 'anti-theorist'. Anti-theorists generally reject the claim 'the pivotal aim and role of a moral theory is to provide action guidance for people'; it is true to say that the term 'anti-theorist' is often used in a derogatory sense.

**The neglect of moral remainder**

Hursthouse, a virtue ethicist, would agree with Williams. Hursthouse has examined the large body of philosophical literature on moral dilemmas, including the possibility that there are, or could be, 'irresolvable' dilemmas. The latter are described as situations "where doing *x* and doing *y* are *equally* [my italics] wrong, but one has to do *x* or *y*, or one in which two moral requirements conflict but neither overrides the other".[20] Most notably for the aims of this thesis, Hursthouse discusses the subject of 'moral remainder', an idea that is embedded in this body of literature. Hursthouse explains this important but neglected subject thus,

> Suppose there are irresolvable dilemmas and someone is faced with one. Then, whatever they do, they violate a moral requirement, and we expect them (especially when we think in terms of real examples) to register this in some way – by feeling distress or regret or remorse or guilt, or, in some cases, by recognizing that some apology or restitution or compensation is called for.[21]

This emotional response - the remorse, guilt, distress, or need for restitution - is the moral remainder, that is, the agent's emotions during and after an irresolvable dilemma. Moreover, Hursthouse believes that when one is dealing with dilemmas that

are thought clearly *resolvable*, these cases are resolvable *only* with remainder. This is because the moral requirement that is overridden retains considerable moral and emotional force.

The subject of moral remainder is somewhat neglected in the moral philosophy literature that examines moral dilemmas. Hursthouse also examines a second body of literature on dilemmas in applied ethics. As an example of this type of dilemma, she gives: should the intensive care doctor lie to the patient who survived a car crash which killed the rest of her immediate family? Hursthouse believes that this second body of literature nearly always ignores the first. Hursthouse holds that the contributors to this literature appear not to "even entertain the possibility that the dilemma they are discussing is irresolvable".[22] Indeed the assumption appears to be that there is one correct decision that the theorists' chosen moral theory will discover. Hursthouse believes that usually deontology or utilitarianism are chosen. Further, Hursthouse believes that the contributors neglect to mention moral remainder, instead they focus, often almost exclusively, on the question "Which is *the right* act in this case, *x* or *y*?"[23]

What accounts for this oversight in ignoring moral remainder in applied ethics debates? Hursthouse believes that writers commit one of several fallacies, and this helps to explain the terrible failure to discuss (or even mention) remainder.

The first possible fallacy is 'the false dilemma'. This occurs when the writer "take[s] the dilemma to be '*either x* is the morally right act to do here (without qualification) and *y* is the one that's morally wrong *or y* is the morally right act (without qualification), etc'".[24] A third possibility is ignored, for example, "'Well, they are both pretty awful, but (supposing the dilemma is resolvable) *x* isn't quite as bad as *y*'".[25] Hursthouse claims that people assume there is, in moral dilemmas, one side that is unreservedly morally right and the other side is simply wrong. This assumption runs, as Hursthouse notes,

deep in ordinary common sense morality and extends to conflicts between two different people.

Hursthouse asks, "Why is the fallacy harder to see when the choice is between two courses of action?"[26] Her response is that this concerns, in part, confusing "two different senses of the phrases 'morally right decision', or 'right moral decision'".[27] In the following quote, Hursthouse illustrates one way in which these phrases are used,

> Suppose we have a moral dilemma which is resolvable *x* is worse than *y*. Then the decision to do *y* rather than *x* is, in the circumstances, the *right* decision. Moreover (supposing the decision to have been made on the moral grounds that *x* is worse than *y*), it is a moral decision, or one that has been made morally. So it is the 'morally right decision' or the 'right moral decision'...[28]

There is a second different way of using the phrases 'morally right decision' and 'right moral decision'. This concerns the use of these phrases to mean a good deed or a morally right act. In Hursthouse's words,

> As such, it is an act that merits praise rather than blame, an act that an agent can take pride in doing rather than feeling unhappy about, the sort of act that decent, virtuous people do and seek out occasions for doing...Moreover, people can take pride in deciding to do such actions- they are the sorts of decision that decent virtuous people make- and are praised for thus deciding, whether or not the act comes off. Suppose it does not come off, well, that is a pity, but still, we say, they made the 'morally right decision', the 'right moral decision'; good for them.[29]

The difference still might not be easy to see, so it will be useful to consider the following claim, which helps to bring the difference out. The claim is "'When morally right decisions come off – when the agent succeeds in doing what she intended to do – we get morally right action'".[30] This applies to the second way of using 'morally right decision'. But, according to Hursthouse, "if we are using 'morally right decision' in the first way, we cannot say this truly, for it is obviously false".[31] Hursthouse gives the following example to illustrate,

> The man who has induced two women to bear a child of his by

> promising marriage, can only marry one, but he may not be in an irresolvable dilemma; it may be worse to abandon A than B, and let us suppose he makes 'the morally right decision' and marries A, perforce breaking his promise to B and condemning her child to illegitimacy. He merits not praise, but blame, for having created the circumstances that made it necessary for him to abandon B; he should be feeling ashamed of himself, not proud, and so on.[32]

The above scenario came about because of the man's intentional actions and desires. Hursthouse, however, still thinks that when the case involves a dilemma brought about through no fault of the agent, the act chosen – the one evil thought marginally less evil than the other – will

> still not be a morally right or good act, not one that leaves her with those 'circumstances [so] requisite to happiness', namely 'inward peace of mind, consciousness of integrity, [and] a satisfactory review of [her] own conduct' as Hume so nicely puts it. On the contrary, it will, or should, leave her with some sort of remainder.[33]

As noted, the resolution of dilemmas in applied ethics literature fails to mention moral remainder. Hursthouse believes that frequently the writers prevaricate on 'morally right decision' and this leads to a false dilemma. Whether this difference between the two senses of 'morally right decision' and 'right moral decision' is concealed on purpose or the writers are truly ignorant of it in the first place, is uncertain. It is hard to accept the latter. However, if the writers did appreciate the difference then it would be good scholarly practice to acknowledge this (perhaps as a footnote) to the readers. It is possible that the writers have not thought about the use of 'morally right decision' and 'right moral decision' in the same way that Hursthouse clearly has. At any rate, there is confusion between two very different questions, namely, "Which is the morally right decision, to do *x* or to do *y*? and "Which is the morally right action...*x* or *y*?"[34] Hursthouse claims, "*If* there are no irresolvable dilemmas, the first question does not pose a false dilemma, but even if every moral dilemma is resolvable, the second certainly does, for the correct answer may well be 'Neither'".[35] For example, during an

armed bank robbery a hostage collapses, clutching his chest. The armed robber has to decide whether to (a) carry on mercilessly or (b) get medical help and allow the doctor to gain access. He decides to do (b). This decision is, on Hursthouse's view, morally right because the hostage is helped; to carry on regardless would have been a greater evil. But one cannot say that the robber's action is morally right because he was acting viciously - robbing a bank is not a good deed - and he should feel guilt and be blamed for creating the situation in the first place. Perhaps the hostage would not have collapsed if the robber had not carried out this vicious act in the first place.

## Problems with utilitarianism

### Ignoring other peoples' rights

The aforementioned quote by Mill makes it quite clear that utilitarianism – in all its forms – is no ally to individual people. This point has been picked up on by other moral theorists, especially rights-based theorists who argue that utilitarian thinking often leads to a violation or overriding of peoples' rights. For instance, because the interests of the many are to outweigh or negate the interests of the few, rights to respecting one's autonomous decision-making capacity can be violated or rights to freedom and liberty can even be outweighed.

One aspect of ordinary morality that has not been touched on is that people very often do think according to crude utilitarian or consequentialist views. Imagine a disagreement where 7 people claim that The Beatles split up in 1969, while 1 person firmly believes it was 1970. The majority of individuals – the 7 – would probably think they were correct and think the other chap is wrong; of course in this example, he would be actually correct. Or suppose a group of people are undecided which film to see at the cinema and it is agreed that the group shall not split up. Six out of ten want to see the new James Bond film, while the other four wish to see the latest film Noir by Hampton. I would suggest that the resolution of this problem would see the group

trotting off to see the Bond film, thus leaving four disgruntled film buffs. While these examples might appear trivial, they are representative of what occurs in ordinary lives. It seems to me that people do spend time – I am not sure how much - thinking about the outcomes and consequences of actions and omissions. I believe too that this might involve some reflection concerning one's needs and interests and the interests and needs of other people. It is clear that the interests and rights of individual people could be ignored, violated or overridden by utilitarian reasoning.

**No action guidance until the second premise.**

Hursthouse examines the first and second premises put forward by act utilitarianism and concludes that it is not until the second premise that one is given specific guidance on how to act morally, that is, told what the right thing to do is. A utilitarian, according to Hursthouse, might initially present her account of right action thus

> P. 1. An action is right iff ['iff' means 'if and only if'; my words] it promotes the best consequences.[36]

However, despite the above linking the utilitarian concepts of 'right action' and 'best consequences', it fails to provide guidance on how to act. One must understand what counts as 'best consequences' for this to be so. Therefore a second premise, specifying this, must be provided. For example,

> P. 2. The best consequences are those in which happiness is maximized.[37]

The above premise forges the utilitarian link between 'best consequences' and 'happiness'. Hursthouse believes, however, that in utilitarianism the slogans do not succeed in singling out the most important notion, for just as the Good is singled out, so too equally perhaps could the concepts of 'happiness' or 'consequences'. Regarding the rather uninformative first premise of act-utilitarianism, Hursthouse thinks

that this point is seldom, if ever, mentioned simply because people are so familiar with how utilitarians specify the notion of 'best consequences'.

But while the second premise of utilitarianism routinely offers no surprises, according to Hursthouse it is possible that obscure things could emerge. For example,

> Someone might specify the 'best consequences' as those in which the number of Roman Catholics was maximized (and the number of non-Catholics minimized). Or someone might specify the 'best consequences' as those in which certain moral rules were adhered to.[38]

It is this familiarity and the ideas that people (intuitively) bring to the subject that help form and maintain this understanding of, for example, the meaning of 'best consequences'. The answer to 'what are best consequences?' is not given in the first premise of act-utilitarianism. But the gaps are filled in because each of us has a pretty good idea of what counts as 'a good consequence', namely something that will, say, produce pleasure or happiness or relieve suffering.

**Utilitarianism's single rule and misrepresenting morality**

Act-utilitarianism and other common conceptions of consequentialism provide just one rule: 'an act is right iff it maximizes best consequences'. A standard objection of utilitarianism is that in applying its single rule, without the need for judgement, "it misrepresents the texture of our moral experience, making it out to be much simpler than it really is". [39] Because it fails to question whether or not its single rule does apply, fails to consider the plausibility of its extension, and denies any higher order rules, it fails to

> capture the number of occasions where we want to say, 'This other (non-utilitarian) rule or consideration just *does* apply here, and it is not simply obvious that it is outranked by the rule about minimizing suffering, though I agree it sometimes is – don't you see?[40]

Furthermore, the single rule of act-utilitarianism is couched in evaluative concepts, such as, 'happiness', 'well-being', and 'best consequences'. Utilitarians can resolve this problem by grounding their form of theory on empirical claims, for example, by defining 'happiness' as the satisfaction of preferences or desires. The single rule of utilitarianism is evaluative, for there are clearly problems for the utilitarian who makes, for instance, a distinction between the higher and lower pleasures.

There is another standard objection to utilitarianism. This is "that, according to non-utilitarians, utilitarianism so frequently yields the wrong resolutions of hard cases".[41] Hursthouse believes that it might be difficult to distinguish between the above two standard objections to utilitarianism. But she claims it is possible to see the difference. There are cases where deontologists (and virtue ethicists) agree with utilitarians that the right thing to do is to minimize suffering. But while the utilitarian simply thinks it adequate and sufficient to apply his single rule, deontologists (and virtue ethicists) think *getting* to this resolution is far from simple,

> for example, in order to avoid a great amount of suffering that would be brought about by keeping it, a promise had to be broken, is something that has to be taken into account; judgement has to be exercised to determine whether this was the sort of promise that could be broken and whether the good effects of doing so are sufficient to justify it, and so on.[42]

So, according to this objection, deontologists (and proponents of virtue ethics) claim it is wrong to equate the content and quality of our deliberations with the simple application of the utilitarians' single rule. This is a claim I fully endorse; indeed it is one of the prime motivations for this thesis on the virtues and virtue ethics.

**Misrepresenting morality: Stocker[43] on modern moral theories' account of moral motivation**

Stocker is dissatisfied with modern ethical theories, including utilitarianism and deontology, for not providing a rich account of the moral life. In his view, these theories *over* concentrate on actions and consequences. Stocker is especially dismayed with obligation-based theories, because they fail to examine moral motives. Or, they provide an account of moral motivation - crudely, the motives for one's actions, thoughts, and feelings – that is so wrapped up in inflexible and strict obligations that it provides an unsatisfactory account of moral motivation. This account is often described as 'unnatural' and 'unconvincing'. A pivotal example from Stocker illustrates this point very well. I quote at length

> ..you are in a hospital, recovering from a long illness. You are very bored and restless and at loose ends when Smith comes in again. You are now convinced more than ever that he is a fine fellow and a real friend –taking so much time to cheer you up, travelling all the way across town, and so on. You are so effusive with your praise and thanks that he protests that he always tries to do what he thinks is his duty, what he thinks will be best. You at first think he is engaging in a polite form of self-deprecation, relieving the moral burden. But the more you two speak, the more clear it becomes that he was telling the literal truth; that it is not essentially because of you that he came to see you, not because you are friends, but because he thought it his duty, perhaps as a fellow Christian or Communist or whatever, or simply because he knows of no one more in need of cheering up and no one easier to cheer up.[44]

How would one feel if this happened? Would one be pleased to hear Smith's motive for his visit? Most probably, one would be disappointed and rather upset to hear that Smith did not visit, because he wanted to be a good friend, or because he really liked you and was concerned about your health. His act appears calculating. In relation to Smith's motive, Stocker says, "surely there is something lacking here - and lacking in moral merit or value".[45]

Smith's actions appear good, even kind. But his motive is the problem. The motivation for his visit is an abstract sense of duty, 'to do the right thing'. People form friendships and relationships with others that are mutually valuable and beneficial. Friendships ought to be made and maintained *for their own sakes*, not because one perceives that there is an obligation to do so. Would one wish to be like Smith? Would one wish Smith to be one's friend? Would one wish to live among people like Smith? The answer to these questions is surely in the negative and an emphatic one at that. And yet, theories of obligation, such as, consequentialism and deontology focus almost exclusively on the idea that people *must* obey certain moral obligations, rules, and principles.

**Act-consequentialism and the problem of intuitions**

An important objection of act-consequentialism (and consequentialism in general) concerns the way it creates conflicts with, or at least fails to accommodate, some of our moral intuitions. These intuitions are held about a range of acts, practices and beliefs in the world. Frey gives the following as examples,

> frown upon murdering or torturing someone, upon enslaving people or using them as means, upon acting in certain contexts and so using people in certain ways for mere marginal increases in utility, all of which act-utilitarianism is supposed to (be able to) license.[46]

Although some intuitions are deeper, more sound than others, the above are all deep-rooted examples of moral intuitions found in Western liberal society. Critics of act-consequentialism, for example, deontologists and virtue ethicists, hold that other moral theories (usually the one adopted by the critic) can better account for, at least, some of these intuitions.

All of these intuitions appear to relate in some way to our respect for persons' lives. As this is a sound and fundamental moral notion, it is particularly interesting to ask, how does act-consequentialism license these intuitions concerning the rightness of acts?

The answer lies with another of consequentialism's main tenets: the act-consequentialist is compelled to call acts right if they have better actual consequences than other alternative acts. For example, if it is thought that act x – to murder a dictator who is responsible for the deaths of thousands of innocent people - will produce the best consequences among three options (x, y, z), then act x, because its consequences are better than y or z, would be the morally right act to perform. However, Frey responds to this form of reasoning by claiming that this conclusion "conflicts with our moral intuitions or ordinary moral convictions"[47] or what, I believe, Slote[48] means by 'commonsense morality'.

**Utilitarianism: impartialism and conflicts between intuitions.**

I shall discuss the above ideas in more depth. People have different needs and interests. However, despite this variety, utilitarianism insists that when deciding what to do, one ought to consider and rate everyone's interests as equally important. J., S. Mill believes that,

> Utilitarianism requires [the person] to be as strictly impartial as a benevolent and disinterested spectator.[49]

Mill has his supporters, including Rachels. In the first chapter of *The Elements of Moral Philosophy*,[50] impartiality is included as a fundamental moral requirement.

But why is the notion about impartiality so important in our moral lives? Why should John be impartial towards his wife, Helen? The basis of close relationships, families, and marriage is love, affection and partiality between those involved. People tend to be partial towards their spouse, family, close friends, and colleagues. Is there anything wrong with mothers who love their children, care for them, put them first, and protect them above all else? Parents tend to care for their own children in ways that they do not care for other children. Parents behave partially all, or nearly all, of the time with their children. What is wrong with this? Isn't this one characteristic of being a 'good'

parent? If parents were not partial, their children might be ignored, feel neglected, or harmed in some way. The same thing applies to how each of us treats our friends. Partialism is a feature of friendship; it is expected between friends. For instance, while Sam would come to the rescue of his best friend, Jake, he might well pass by a stranger in need, because Jake has not met this stranger and feels no affinity towards him. An important part of our moral lives concerns friendships with, and affection for, others. Moral theories, such as utilitarianism, which urge impartiality, find it difficult to account for these aspects of the moral life. Indeed utilitarianism provides a crude, simplistic account of this morally important feature that fails to portray real life as it is.

Critics of act-consequentialism argue that many moral intuitions support partiality towards loved ones and ourselves; that one should put their own needs and interests, and those of loved ones, ahead of others, especially strangers. This idea appears sensible since persons are morally responsible for one's own lives. But while one can help others, including strangers, and aid their distress, one is not morally responsible for others' lives as a whole. And of course, if one neglects their own life one might be unable or less able to help others. In sum, critics claim that act-consequentialism produces conflicts with or fails to accommodate some of our deeper moral intuitions.

But what about those occasions when moral intuitions and the claims made by consequentialism coincide? Frey believes this omission – it is seldom mentioned – is noteworthy. One explanation why this might be so is that the critic of act-consequentialism somehow believes that these established intuitions are either compatible with, or are produced from, his theory of the right. Two possible positions emerge from this,

> on one of which rightness has nothing whatever to do with an act's consequences and on the other of which the rightness of certain acts has nothing whatever to do with an act's consequences.[51]

It will become clear in this thesis that virtue ethics is an example of the first position. There is also a third position, noted by Frey, which is not anti-consequentialist. This view holds that the rightness of an act concerns its consequences plus something else, for example, the motive from which the act was performed. This view is a combination or hybrid account. While it might not be anti-consequentialist, its action guidance will depend on the moral force given to the motives that are taken into account when determining the rightness or wrongness of the act.

**Which intuitions are deeper than others?**

It was noted earlier that some moral intuitions are thought more secure or deeper than others. Indeed, according to Frey, some philosophers believe that certain deeper intuitions are more true than any normative moral theory. This begs a couple of questions, one of which I will deal with and the other I will put to one side. First, I will set aside the question of whether moral intuitions have probative force in ethics.[52] I will instead deal with the following question, which intuitions are more secure than others and why? Critical thinking is needed to respond to this question. However, according to Frey, irrespective of which critical methodology is adopted, some intuitions remain intact and survive after intense critical scrutiny. Rawls[53] believes that if one's chosen moral theory produced a result that was contrary to one's deep intuitions, for example, if slavery was justified by the theory, then this provides sufficient reason for one to revise or amend the theory.

Another problem arises in attempting to clarify which moral intuitions are more secure or deeper than others. There is disagreement on this because of factors including cultural diversity and gender differences. Whatever the reason though, the outcome is that thinkers side with different intuitions concerning particular acts or classes of acts which they regard as crucial. Therefore the goal of arriving at just one or two deep and secure intuitions is complicated. Problems remain, in my view, regarding exactly how

one can compare the deepness or correctness of moral intuitions. I believe the fact that several intuitions are proposed as crucial indicates wide variation and a lack of consensus among thinkers. And holding more than one or two reduces the strength of the intuitionist's claims. One also needs to note the effect of historical eras on one's willingness to label some intuitions as more favourable or correct than others. For example, Frey believes that whereas truth telling and promise keeping were once highly favourable, secure intuitions to hold, nowadays opinion has altered somewhat. For example, Frey states that the wrongness of abortion has *perhaps* [my italics] taken over as one of the more secure contemporary moral intuitions. However, there is no empirical evidence for this, indeed there are no reasons given in support of Frey's claim. He does believe, however, that one's moral intuitions depend, to a large extent, upon one's political orientation,

> someone who is politically conservative not uncommonly puts the wrongness of abortion into the favoured class, whereas political liberals are very unlikely to agree.[54]

Perhaps, then, Frey believes that the secure moral intuition regarding the wrongness of abortion is true *if* one is a conservative. Because of the large number of conservative voters (Frey is an American, does he therefore mean republicans?), he might firmly believe that there are many people who would hold and defend this moral intuition. However, this discussion demonstrates the difficulty in defending moral claims, in this case concerning assumptions about the number of people holding a moral intuition about the wrongness of abortion.

Whatever the disagreements between the scope, depth, and limits of moral intuitions, attacks on act-consequentialism are very often launched because of the assumption that some intuitions remain despite critical scrutiny. It is hard to see how such intuitions as 'slavery is morally justifiable' could survive once rigorous critical examination has been conducted. Indeed, as discussed above, an intuition of this kind would probably

require an amendment in the moral theory that grounds it. If an intuition survived critical reflection, it would most probably be a legitimate and defensible one.

Motivated by this problem regarding intuitions, theorists have aimed to develop act-consequentialism by incorporating all manner of conceptual devices into the structure of the theory (I shall focus on Hare's indirect form of consequentialism in a later section). The aim is that results can then be obtained in particular cases that are more compatible with the deep and secure intuitions identified by critics of act-consequentialism. Sidgwick is, according to Frey, one example of the aforementioned kind of thinker. In Book IV of *The Methods of Ethics*[55], Sidgwick aims to convince readers that act-consequentialism does indeed provide support for aspects of commonsense morality; although he admits that there are parts and details of the theory that are incompatible with commonsense morality and hence require reformulation. Sidgwick took the view that amending act-consequentialism was necessary to respond to some of the conflicts between the application of act-consequentialism and the views taken to be representative of commonsense morality. This view is in opposition to the hard line utilitarian view adopted by Smart.[56] However, according to Sidgwick, it remains the case that act-consequentialism is unable to sweep aside all of commonsense morality, so that with regard to justice, for example, act-consequentialism should give way.

**Intuitions – the need for supporting argumentation**

This debate over the correctness of moral intuitions leaves me wondering how two claims can be squared. On the one hand, Rawls' claim that slavery is morally unjustifiable and that nothing more needs to be said to defend this position. And on the other hand, the idea that moral philosophy, or more strictly philosophical analysis, is intended to be a rigorous pursuit, which aims to search for, and defend, secure foundations for moral beliefs. One is left with the feeling that Rawls has not been

successful here, or at least he fails to go far enough. More is needed concerning the legitimacy and justification of Rawls' claim regarding slavery. This is true even if one agrees (as I do) with his view that slavery is morally wrong. One is required to provide supporting reasons for one's beliefs so that others can then evaluate these. It is possible that one could hold deep moral intuitions, which others might abhor, for example, extreme racist views. It is therefore crucial that supporting argumentation is provided, which allows for investigation and critical examination.

If commonsense morality with its secure moral intuitions about particular acts is a plausible view, then this provides problems for act-consequentialism. Despite epistemological concerns, for example, what justifies moral intuitions?, I accept that people often hold deep intuitions about a range of acts in the world, including the wrongness of murder, slavery, and torture. Act-consequentialists are motivated to bring their theory into line with some of these deeper moral intuitions. However, as a result of doing so, act-consequentialists minimize their theory's merits, for example, its alleged simplicity. (But it is arguable whether consequentialism, especially the utilitarianism of Smart, could accurately be described as a simple moral theory.) Nevertheless, viewing act-consequentialism, as a plausible moral theory would be further hampered if it failed to account for some deeper moral intuitions, especially those thought too secure to be mistaken, which besides the aforementioned include the evil of child abuse.

## Merits of consequentialism

### It avoids the charge of moral relativism

One of the merits of act-utilitarianism, its proponents allege, is that it avoids the charge of moral relativism, which affects deontology (and virtue ethics). This is because act-utilitarianism's first premise, unlike deontology's, contains just one rule: 'an action is right if it produces the best consequences'. Of course, one then needs to know what 'best consequences' means; this is given in its second premise 'best consequences

are those that maximize happiness'. It is plausible to suggest that act-utilitarianism is not guilty of moral relativism.

**Consequentialism is codifiable**

Another feature of consequentialism (and deontology) is that they aim to be codifiable, that is, these theories hold that ethics should be conceived as a set of obligations, rules, and principles that provide specific action guidance. This is held, almost assumed, to be one of consequentialism's merits. Pincoffs[57] noted that this was the dominant view of a normative ethics. According to Hursthouse, codifiability means that universal obligations, rules, and principles possess two features,

> (a) they would amount to a decision procedure for determining what the right action was in any particular case; (b) they would be stated in such terms that any non-virtuous person could understand and apply then correctly.[58]

Hursthouse calls this 'the strong codifiability thesis'. While this feature can be seen in a positive light, one can also understand that it could, if other morally important features were forgotten, prove objectionable.

## Rule-consequentialism

Rule consequentialism has arisen and developed in no small part because of the flaws in act-consequentialism regarding its conflicts with some secure moral intuitions. Rule-consequentialism develops rules that are judged morally right if the consequences of adopting such rules are thought more favourable than unfavourable to the majority of people. Rule consequentialism does not judge or test the morality of particular actions, rather it tests the morality of rules such as 'lying is wrong' or stealing is wrong'; adopting rules such as these is usually thought favourable for everyone. Because it does not target specific acts, rule consequentialism provides more general action guidance for people compared to the single rule of act-consequentialism. However, does rule-consequentialism fare better than act-consequentialism? Not according to

Frey, who believes that, in at least the versions of rule-consequentialism known to him, it "has long been known to suffer from certain types of instabilities that seem irreducibly part of the theory"[59]. This view is shared by Lyons[60] who claims that rule-consequentialism collapses into act-consequentialism. It is certainly true that in avoiding the problems associated with act consequentialism, new problems are created for rule consequentialism. For example, under rule consequentialism it might be thought socially beneficial to introduce a rule prohibiting slavery. However, it is possible that "on balance, a rule permitting slavery actually produces more benefit for society".[61] Part of the problem is that once one agrees that certain moral intuitions have an important role to play in morality and once one thinks that some of these intuitions are true, it becomes more difficult to accommodate these intuitions within a consequentialist structure. In other words, rather than trying to maintain some sort of consequentialist theory, it might be more profitable to turn to moral intuitionism instead. Given this and the importance of deeper moral intuitions, it might be that a non-consequentialist moral theory could better accommodate these intuitions. Critics of both kinds of consequentialism (and more specifically, act and rule utilitarianism) suggest that this flaw – consequentialism's inability to accommodate deeper moral intuitions - explains why these forms of moral theory have failed to catch on. I accept that the conflict produced by act-consequentialism with regard to some deeper moral intuitions provides it with a serious problem. But I would disagree with the assertion that act-consequentialism has not caught on. Of course, a lot depends on precisely what is meant by 'to catch on'. But from electronic searches of the general ethics literature, it is evident that obligation-based moral theories in general, and consequentialism in particular, are popular, if not to say dominant, theories in the literature. (The nursing literature searches produced very similar results – this will be discussed in Chapter 6.)

**Hare's indirect consequentialism**

Hare[62] has famously developed an indirect split-level account of act consequentialism in an effort to better accommodate those secure moral intuitions that remain after critical examination. Because Hare's theory aims to respond to important criticisms of act-consequentialism, I shall now spend some time examining his account.

Hare disagrees with the common notion that deontological (or in his words, 'absolutist') and utilitarian methods of moral reasoning are incompatible. He claims that it is possible to distinguish between two different levels of moral thinking, and that this is a potentially viable and productive approach. Hare thinks that the absolutist approach is most suited to problems, which one faces "without much time for reflection about them", [63] whereas the utilitarian approach is most suited to moral problems "which we think out, in general, what our attitudes to these problems ought to be".[64]

Hare briefly outlines the two approaches, absolutism and utilitarian. He has this to say about the former,

> We have first those who tend to speak in terms of people's rights and the corresponding duties of other people towards them - rights and duties which are thought of as in some sense absolute.[65]

However, according to Hare, this approach fails to tell us *what* rights one has or when conflicts arise, *which* rights are to be respected and which overridden (I examine the notion of rights later in this Chapter).

The utilitarian approach concerns doing what is in the 'best interests' of people, aiming to ensure that what is done will promote one's interests and welfare. For Hare, however, a true utilitarian is impartial, that is, everyone's interests are treated equally. For example, within health care, Hare claims that in the majority of cases a patient's interests will take precedence over the interests of others. Thus, a utilitarian would

make his decisions on the basis of the patient's interests. Hare conceives a utilitarian to be,

> One who thinks that when faced with a moral decision he ought to act in whichever way is best for the interests of those affected.[66]

Hare criticizes the practice by philosophers and bioethicists of proposing obligations, for example, the duty of beneficence, and calling for a weighing of such duties when there are conflicts between these. He rejects this practice mainly because no explanation is provided for whichever so-called solution is suggested. Hare also rejects the method of 'lexical ordering', where an attempt is made somehow to prioritise duties. This is another common objection levelled at obligation-based ethics, one that is often overlooked when one is given long lists of different kinds of duties, for instance, *prima facie*, perfect, imperfect, 'x stricter than y' and absolute. Despite this confusion, one is expected to be able to use these as decision-making guides. Hare makes a second point in relation to lexical ordering. He asks, will there not be situations when this ordering will not work out? For example, suppose that the duty to respect a patient's autonomy is ranked higher than the duty of beneficence. Will there not be occasions when the latter will be considered more morally important than the former? Examples of this sort of disruption to lexical ordering abound in nursing, often giving rise to paternalistic interventions.[67] Thus, one's sense of not knowing how to proceed is compounded.

Hare's initial premise behind this two-level account of moral reasoning is that a single level of moral thinking cannot resolve conflicts, for "if conflicts arise at one level, they cannot be resolved without ascending to a higher level".[68] He cites the famous (since Kant) example of,

> a madman is seeking out a supposed enemy to murder him, and I I know where the proposed victim is; do I, if I cannot get away with evasions, tell the truth to the madman?[69]

According to an absolutist, the conflict can be resolved by calling one of the duties absolute and the others given weaker status. In this example, telling the truth might be held to be stricter, and therefore, the proposed victim's life will be sacrificed. In contrast, the utilitarian is not so concerned with this type of duty. According to him, neither duty is to be given absolute status; instead, one has to try and work out what will be for the best all round. If one considers the interests of all concerned impartially, what will do most good? The response, presumably, would be to tell a lie. However, Hare notes an objection here concerning the utilitarian's failure to acknowledge *any* duties, for example, truthfulness is ignored because maximizing utility is seen as the sole aim.

Hare claims that the above kind of dispute can be resolved if the two levels of moral thinking – intuitive and critical - are distinguished. According to him, "at the intuitive level, we have these intuitions about duties and it is a good thing that we do".[70] The development of a conscience depends upon these intuitions, whether utilitarian in outlook or not. This serves a socially pragmatic role, as Hare believes that firm dispositions are invaluable to maximizing utility. However, what happens when conflicts among these intuitions arise? One cannot appeal to intuitions to resolve conflicts between intuitions. On those occasions when one wants to know which intuitions one should have or exactly which duties one ought to abide by, one will need to appeal to some other feature of morality.

At the critical level, there is no appeal to intuitions, instead the utilitarian is given the monopoly. Hare writes,

> We form in ourselves and others, for good utilitarian reasons, sound intuitions prescribing duties, and the disposition to feel bad if we go against them; the content of these intuitions is to be selected according to the good or bad consequences of our acquiring them; when they conflict in a particular case, we have to apply utilitarian reasoning and do the best we can in the circumstances; but when the case is clear and there is no conflict, we are likely to do the best

by sticking to the intuitions.[71]

Hare describes in further detail both levels of moral thinking. He claims that the intuitive level is predominantly concerned with making moral decisions faced in everyday life. These intuitions or habits of thought (Hare thinks it unimportant what these are called) have been cultivated and developed during our childhood and upbringing. He believes that people usually follow these *prima facie* duties and principles, without much reflection. However, there are at least two reasons why the intuitive level is insufficient for moral thinking. First, these moral intuitions do not by themselves demonstrate that one's moral judgements are correct because, for example, the moral education that developed these intuitions might have been misguided, such as, that cultivated within a deeply racist environment. Second, in order to be useful, these *prima facie* principles need to be simple and easy to follow. However, as a result of this simplicity, cases arise in which these principles conflict and yield no determinate answers. I suggest however that this criticism applies not only to thinking at the intuitive level, but also to moral reasoning *per se* using an obligation-based approach. This is partly because this approach aims at (a) making moral decisions and (b) resolving moral dilemmas.

Hare goes on to claim, because of the above, that both levels of moral thinking are required for a complete account. In summary, he holds that

> the critical level is that at which we select the principles to be used at the intuitive level, and adjudicate between them in cases where they conflict.[72]

But how does one manage to do the above and know precisely when to engage in critical thinking? Hare's own account is based upon philosophical and logical analysis. Words such as 'ought' and 'wrong' are analysed,

> in order to determine clearly, first their meanings, and then, as part of these, their logical properties; and thus, as a consequence of their logical properties, the rules for arguing about questions formulated in terms of these concepts.[73]

Most intuitions are moral, although some are logical or linguistic. It is pointless to appeal to intuitions to settle conflicts between intuitions. Logical intuitions are not expressed in moral judgements, but in statements of logic, that is, in terms of the logical consistency and coherence of propositions and sentences. According to Hare, the failure to distinguish between these two types of intuitions is responsible for much confusion in moral philosophy.

Hare believes that moral judgements provide us with universal prescriptions that can form the foundation of a plausible account of moral reasoning, "which supports most of our common moral convictions".[74] For example, he writes,

> most of us accept the principle that it is wrong in general to confine people against their will. If 'wrong' expresses a negative universal prescription, or universal prohibition, this is easy to explain. For then in saying that it is wrong to do this, we are prescribing that it never be done. And the reason why we are ready to prescribe this is that we imagine ourselves in various circumstances in which other people might wish to confine us against our will, and unhesitatingly prescribe that they should not.....it is not difficult to see intuitively that one who is prepared to prohibit involuntary confinement in all hypothetical cases in which he would be the victim will be prepared to assent to a general prohibition.[75]

Hare believes that exceptions to general principles can be included. However, because people are not superhuman, do not have complete information, or infinite time at their disposal, one merely has to do the best one can in the particular circumstances. When one has sufficient time, one can do the best critical thinking possible. It is hoped that one can then establish a set of general, *prima facie*, and relatively simple principles for use at the intuitive level.

These principles are selected having taken into account real life and the sorts of situations one might face, therefore extreme examples do not arise nor count against the theory. It is then, according to Frey, likely that acting in accordance with these principles will produce overall consequences that are as good as alternatives.

However, doubt should be raised on the certainty of such claims. A necessary component of consequentialist theories is their ability to predict the consequences of acts, that is, to posit claims about future events. How one does this and the degree of certainty one can have with such beliefs is open to debate.

Hare's account is indirect because, due to the two distinct levels of thinking, no direct and extensive appeal is made to an act's consequences. The effect of this is that act-consequentialism is redundant at the intuitive level; there is no application of consequentialism on a case-by-case basis. And, as noted, it is the latter that is the source of much of the disagreement between act-consequentialism and ordinary morality. Therefore the conflicts that arise in direct consequentialism do not arise in indirect consequentialist thinking, or at least this is what advocates of indirect consequentialism allege.

Hare's indirect form of consequentialism has other merits too. As noted above, at the intuitive level, there is no consequentialist thinking on a case-by-case basis. On this, Hare writes,

> in seeking to maximize human well-being on each and every occasion, we may fail to maximize human well-being overall; we may do better overall not to try to maximize well-being on each occasion.[76]

At the critical level where act-consequentialist thinking is employed to produce the action guidance principles executed at the intuitive level, there is no good reason why these principles cannot include deontological features, such as, moral duties or rules. Therefore, Hare's account responds well to common charges made against direct consequentialism by deontologists, because it accommodates deep moral intuitions and makes moral duties and rules part of the theory too.

I shall summarize Hare's work on indirect consequentialism. Direct consequentialist thinking produces conflicts with some secure and deep moral intuitions. The act thought to have the best consequences might be frowned upon and rejected as the right act by some of these moral intuitions. Indirect consequentialist thinking avoids this problem,

> it has the act-utilitarian acting in accordance with the general rules, duties, and rights – all of which can bar direct appeal to consequences in order to determine rightness – selected by act-utilitarian thinking as giving us the best chance overall of maximizing human well-being.[77]

**Criticisms of Hare's theory**

General objections remain in relation to the uncertainty of successfully predicting an act's consequences. More specific criticisms can be levelled at Hare's theory, however. While the core of this indirect theory remains act-consequentialist, deontological rules and duties can also be found within its structure. But such rules and duties, while embedded within the theory, are not present in the foundation of the theory. Moreover, according to deontologists, it is these rules and duties that really matter in ordinary morality, thus indirect consequentialism remains seriously flawed. Furthermore, these 'general rules, duties and rights' might include, for example, obligations of beneficence, respect for persons' autonomy, rights to liberty, and the duty not to harm others. Because of such diversity, this two level indirect account of consequentialism requires rigorous consequentialist *and* deontological theories. If not, then superficiality and inadequacy, in terms of providing moral guidance, would result.

Proponents of indirect consequentialism, such as Hare, would not be impressed with this objection. Hare's account aims to show that, unlike direct consequentialism, doing act x for a mere marginal increase in utility is not a morally right or correct act. In this respect, it is a fruitful attempt to make consequentialism a less stringent moral theory. In response to this criticism from deontologists, the indirect consequentialist could ask,

why does it matter that rights and duties are not foundationally embedded in the theory? Advocates of deontology might respond by stressing that, according to their lights, hybrid theories are less coherent than single theories, because by definition hybrids rely on a merging of two or more largely incompatible theories. As such, hybrid theories are thought less adequate and provide less clarity regarding action-guidance, that is, telling people what to do.

Indirect accounts of consequentialism, despite their attempts to modify the theory, still remain focused on the major tenets of obligation-based theories. These include: the importance of consequences in morality, the focus on the notion of 'right action' and action-guidance, maximizing, or at least satisfying, one's interests, and in the case of utilitarianism, viewing everyone's interests, including strangers, as equal. Therefore, indirect consequentialism continues to provide an incomplete and hence inadequate account of the moral life.

**Consequentialism – conclusions**

Consequentialism clearly demarcates between right and wrong acts. It provides, at least on some accounts, a simple and intuitively appealing explanation of what makes right acts right and wrong acts wrong. However, consequentialism has been criticised on the grounds that it can be difficult for people to foresee *all* of the possible consequences of *all* of one's acts. And indeed, it is hard to know what these consequences will be, even in those cases considered straightforward.

Act-consequentialists have attempted to respond to criticism that their theories fail to accommodate aspects of commonsense morality. These strategies go some way to accommodating deeper moral intuitions, which is a positive move.

However, the versions of consequentialism discussed have several things in common. First, they aim to provide action guidance. Second, they aim to develop decision procedures. Third, they aim to provide an account of the Right. However, in my view, more notable is the fact that these theories ignore completely or neglect to discuss several other morally important features. Examples of these other morally important features are providing a rich account of persons' moral character, the idea of moral education, and the role of the emotions in morality. I have noted several objections that are commonly levelled at the *content* of consequentialist theories. Furthermore, because of the aforementioned *omissions*, I argue that act, rule, and indirect consequentialism are incomplete and thus inadequate moral theories.

**Deontology**[78]

Deontological theories can be characterized as 'backward looking'. These theories again begin "Act x is right if ____", but instead of filling in the blank by reference to the consequences of an act, they typically claim that what makes right acts right (and wrong acts wrong) is some other morally important feature that occurs at the same time as or before the act. However, as with consequentialists who often disagree about what the good and bad consequences are, or who the recipients of the consequences should be, or whether such a theory should be a maximizing theory, deontologists often disagree over what these morally important features are. For example, some insist that moral principles that encapsulate the intention or motive behind the act should be paramount, others look to divine commands, and yet others look to intuitions. Agreement however is reached on one idea: "the end doesn't always justify the means". In other words, good consequences alone are not sufficient to make an act morally right; and conversely, bad consequences do not necessarily make an act morally wrong.

Moral philosophers who advocate some form of deontology differ over the precise role attributed to consequences in morality. For example, Kant[79] held that consequences were completely irrelevant to an act's rightness or wrongness. Others, such as Ross[80], are less radical on this believing that while consequences might be relevant, there are others features – the intrinsic value of moral principles, intentions and motives, to name but three – that can be regarded, at least sometimes, as more important.

**Contemporary Deontology[81]**

To promote an understanding of deontology, it is fruitful to look closely at differences between deontological and consequentialist moral theories.

It is clear from the aforementioned introduction that deontologists believe that there are some acts that are intrinsically wrong; wrong because of the sort of act they are. These sorts of acts are, irrespective of the consequences, morally unacceptable and impermissible. Even ends that might appear morally admirable cannot legitimately be achieved by these unacceptable means. According to Davis, deontologists hold that

> acting morally, or as we ought to act, involves the self-conscious acceptance of some (quite specific) constraints or rules that place limits both on the pursuit of our own interests and of our pursuit of the general good.[82]

While this might be true, deontologists also usually agree that neither is it morally required for us to (a) always aim to promote our own interests or (b) pursue the general good. Deontologists think morality is largely a matter of sufficiency and neither of the above pursuits provides sufficient moral grounds for action.

Deontologists are dissatisfied with consequentialism for several reasons, most of which have been noted in the previous section. Furthermore, consequentialist theories can be criticised, according to deontologists, on the grounds that they encourage or allow

us to sometimes treat other humans in inhumane ways. Deontologists often allege that such consequentialist theories misunderstand or misinterpret what it is to be a person.

Rawls argues that theories of right action can be exhausted by reference to just two categories: teleological and deontological. He writes,

> The two main concepts of ethics are those of the right and the good... The structure of an moral theory is, then, largely determined by how it defines and connects these two basic notions...The simplest way of relating them is taken by teleological theories: the good is defined independently from the right, and the right is defined as that which maximizes the good.[83]

Rawls contrasts a deontological theory with a teleological theory in two ways. First, the former do not "specify the good independently from the right" [84] and second, deontological theories do not "interpret the right as maxmizing the good".[85] Fried goes further on the relationship between the good and the right,

> The goodness of the ultimate consequences does not guarantee the rightness of the acts which produced them. The two realms are not only distinct for the deontologist, but the right is prior to the good.[86]

At least three things can thus be said about deontologists' views on the right and the good. First, the Right is not definable in terms of the Good. Second, the claim 'the Good is prior to the Right' is rejected. And third, there is no clear relationship between doing right and doing good.

For deontologists, acting right is concerned with refraining from doing things that are known (before the fact) to be wrong. Davis refers to the requirements that restrain us from doing these sorts of acts as 'deontological constraints'. These include various laws, rules, principles, prohibitions, proscriptions and limitations. Persons are obliged, according to deontological views, to refrain from doing acts known to be wrong

> even when they foresee that their refusal to do such things will clearly result in greater harm (or less good).[87]

An obvious observation can now be made: deontological views are non-consequentialist. Also, the former are non-comparative and non-maxmizing. According to a deontologist, the wrongness of telling lies has nothing to do with the possible bad consequences of telling a particular lie or the general negative effects of lying. Rather, the wrongness of telling lies on the deontological view is

> because of the sorts of things they are, and are thus wrong even when they foreseeably produce good consequences.[88]

Consequentialist theories, as noted, are based on an impartial consideration of others' interests or welfare, while deontological views clearly are not. A typical example (given by Davis) clarifies this point. Imagine a scenario whereby one might harm one innocent person to prevent the deaths of five innocent people. If a deontologist refuses to harm the one, knowing full well that this (impermissible) act would prevent five innocent deaths, then this clearly shows that the interests of the six do not count, or at least do not count equally. If this was the case, that is, their interests were all taken into account equally, then this act (to harm the one) would not only be permissible, but most probably obligatory. However peoples' interests are complex and cannot be satisfactorily perceived and evaluated in this crude way. This point is noted by deontology, deontological views are not based on an impartial consideration of interests. As Davis explains,

> For that [impartially considering interests] would seem to allow – if not require – that each one of the five's interests be weighed against those of the one; it would seem to allow – if not require – us to (for example) toss a coin five times, in order for each of the five's interests to receive the same consideration that the one's interests are accorded.[89]

There is another area in which deontological views differ from consequentialist impartiality. Deontologists insist that one is not allowed to violate a deontological constraint, by doing a particular act,

> even when our doing so would obviate the necessity of five other

> people being faced with the decision to violate a deontological constraint or allow even more serious harm to occur.[90]

Deontologists hold that it is forbidden to harm one innocent person to decrease the number of deaths. Moreover it is forbidden to harm one to decrease the number of killings carried out by other people who possess the character and motivations considered no worse, morally, than ours. As noted earlier, consequentialists hold that everyone's interests, including one's own, should be judged impartially. Thus one could claim that this stringent tenet of impartialism leads consequentialism to deprive one of, or at least interfere with, ones' personal autonomy. A consequentialist assesses his own interests, in effect, his life, as no more important than the interests of a total stranger. But surely, Davis claims, if one is to have and sustain lives worth living, then one ought (and needs) to assign more weight to one's own interests, simply because one's interests form one's life.[91] This favouritism is more than merely tolerated by deontologists. Respecting personal autonomy may mean that one prioritises and gives more weight to one's own interests and concerns, compared to those of others.

Deontological views provide more weight to one's own avoidance of wrongdoing ('wrongdoing' here means a violation of deontological constraints), compared to the interests and lives of others. Moreover, deontological views

> require that we assign more weight to our own avoidance of wrongdoing than we do to the avoidance of wrongdoing *tout court*, or the prevention of wrongdoing to others.[92]

Ultimately by a deontologist's lights, the preservation of one's moral integrity and excellence is not only more important than the preservation of others' lives, it is also more important than the preservation of others' moral integrity and excellence. Commenting on this issue, Davis remarks

> We may not save a life with a lie even when the lie would prevent the loss of life by deceiving an evil agent who credibly intends to

kill several innocent victims. [93]

## Deontological constraints

There are three features of deontological constraints – the system of prohibitions or rules that form the basis of deontological views – that require closer inspection. These are that constraints are (a) usually formed as negative formulations, (b) usually narrowly framed and bounded, and (c) usually narrowly directed. Each of these will now be discussed in more detail.

### Deontological constraints - negative formulations

Deontological constraints are usually formulated as 'Thou shalt nots' or prohibitions. While it might be theoretically possible to transform these negative prohibitions into positive prescriptions – for example, 'do not tell lies' would become 'tell the truth' – deontologists regard the latter as inequivalent to negative prohibitions. While the deontologist is aware that the same bad or untoward consequences might arise from 'lying' and 'failing to tell the truth', and that these kinds of acts might arise from the same kind of motivations, it is also clear that 'lying' and 'failing to tell the truth' are not the same kinds of act (another example would be 'harming' and 'failing to benefit'). 'Kinds of acts' are the objects which deontologists deem right or wrong. It will therefore be possible for a deontologist to forbid 'lying' (one kind of act), while perhaps being ambivalent on 'failing to tell the truth' (a closely related, but different kind of act). On this Fried thinks,

> In every case the [deontological] norm has boundaries and what lies outside those boundaries is not forbidden at all. Thus lying is wrong, while withholding a truth which another needs may be perfectly permissible – but that is because withholding a truth is not lying.[94]

**Deontological constraints - narrowly framed and bounded**

The second feature is that deontological constraints are usually narrowly framed and bounded. This means that a person's obligations and other deontological views are explained in narrow terms and quite restrictive. Davis believes that this is important because one's understanding of a person's obligations and responsibilities will depend, in part, upon one's understanding of the scope of deontological constraints. And, as she notes, this will include various contrasting views about what constitutes different kinds of acts.

**Deontological constraints - narrowly directed**

The third feature of note is that deontological constraints are narrowly directed. This means that these constraints attach narrowly or specifically to peoples' decisions and acts, rather than generally to any of the possible consequences of their decisions and acts.[95] Nagel says on this point, "Deontological reasons have their full force against your doing something – not just against its happening".[96]

## Intention and foresight in deontology

The distinction between intention and foresight is often explicated to help explain the narrow-directedness of deontological constraints. This distinction holds that only if one intentionally harms another does one violate the constraint against harming the innocent. If for some reason, one chooses not to take action to prevent harm befalling others, then this is not a violation of the deontological constraint against harming the innocent. This remains the case if the harm that befalls someone is foreseen as a possible consequence of one's permissible action, as long as one's action was not a chosen means or towards a chosen end. However, one's action might be open to criticism on other grounds. According to deontological views and expressed in commonsense morality,

> we are not as responsible for (or not fully agent of) the foreseen consequences of our acts, as we are for the things we intend.[97]

As noted earlier, the majority of deontology's obligations are formulated negatively as prohibitions or impermissions. For deontologists, the category of the impermissible is fundamental because it grounds the definition of the obligatory: "what is obligatory is what it is impermissible to omit".[98] However, it is unclear what people are obliged to do. Nevertheless, agreement surrounds the idea that people need to devote most of their time and energy to the realm of the permissible. On this, Fried remarks

> One cannot live one's life by the demands of the domain of the right. After having avoided wrong and doing one's duty, an infinity of choices is left to be made.[99]

A stark contrast emerges between consequentialism and deontology. For consequentialists, the notion of the Right is strong and prior to the Good, while for deontologists the Right is usually held to be a weaker notion, deontologists tend to make the Good prior to the Right. Consequentialism in general terms holds that a course of action is permissible

> when and only when it is the best (or equal best) option open to an agent: it is never permissible to do less good (or prevent less harm) than one can.[100]

Thus in a sense consequentialists achieve what Davis calls moral closure: "every course of action is either right or wrong (and actions are permissible only if they are right)"[101]; this 'simplicity' is seen as one of the merits of consequentialism. Contrast this with deontology's views: an act might be permissible without it being the best act or even a good option.

The above tenet of consequentialism attracts criticism because it ensures that consequentialism is a strenuous and rigid moral theory; there is a lack of what Davis

calls 'moral breathing room'. In summary, for deontologists, consequentialism makes mistakes relating to the notions of permission, obligation, and the Right.

**Deontology and the 'doctrine of double effect'**

Although there are problems surrounding the tenability of the distinction between intention and foresight, many deontologists appeal to this to provide a plausible meaning of narrow-directedness. In describing the 'doctrine of double effect', Nagel states

> to violate deontological constraints one must maltreat someone else intentionally. The maltreatment must be something that one does or chooses, either as an end or as a means, rather than something one's acts merely cause or fail to prevent but that one doesn't aim at.[102]

If one did not intend to do the act in question, then one cannot legitimately be accused of violating a deontological constraint. One might have done something wrong, but if it was not one's chosen end or means then, according to this doctrine, one has not done anything wrong at all.

It is possible to see the connection between narrow-directedness and narrow framing. The prohibitory force of deontological constraints attaches only to those things intended. Given this, it is clear that, for example, a lie is a different kind of act than is a failure to tell the truth. Lies (as attempted deceptions) are necessarily intended, while failures to disclose the truth do not necessarily aim at deception. Furthermore, accept that the concept of intention is developed and explained in terms of choice as a means to an end. For example, something counts as an intentional harming of the innocent only if it – the harm – was chosen either as an end or a means to an end. If this plausible claim is accepted, then foreseen harms are different from harms chosen as a means to preventing others' harms. In Davis' words,

> If an agent harms one person in order to prevent five others

> from being killed in a rockslide, what he or she does is an intentional harming, and thus violates a deontological constraint. But if the agent refuses to kill the one to save the five, then, since the deaths of the five are not the agent's chosen means or the agent's chosen end, there is no violation of a deontological constraint.[103]

Consequentialism faces problems because of its need to predict the consequences of an act. Does deontology avoid such practical problems? There is no need by deontology's lights to speculate about the possible consequences of an act since, as noted, deontologists believe that acts are wrong (or right) because of the sorts of acts they are. Possible lists of wrong acts drawn up by deontologists will have in common that, in some way, they violate one or more of the deontological constraints. Nagel provides perhaps a representative list:

> Common moral intuition recognizes several types of deontological reasons – limits on what one may do to people or how one may treat them. There are special obligations created by promises and agreements; the restrictions against lying and betrayal; the prohibitions against violating various individual rights, rights not to be killed, injured, imprisoned, threatened, tortured, coerced, robbed; the restrictions against imposing certain sacrifices on someone simply as a means to an end; and perhaps the special claim of immediacy, which makes distress at a distance no different from distress in the same room. There may also be a deontological requirement of fairness, of even-handedness or equality in one's treatment of people.[104]

However, while it appears that deontologists do better than consequentialists in this area of morality, some theoretical problems remain. If deontologists reject the link between an act being wrong (or right) and its bad (or good) consequences, then what is it about a wrong (or right) act that makes it wrong (or right)? In other words, why are the items on Nagel's list above, there? (And Nagel's list is fairly representative of deontology.) In reply, deontologists can appeal to several sources. For example, some deontologists appeal to common moral intuitions, while others appeal to religion, for instance, Judaeo-Christian teachings.

However, deontological constraints are also derived from another more fundamental principle. This principle is frequently presented as something like 'it is morally obligatory to respect every person as a rational agent'. The foundation for this principle is held to be Kant (discussed further in Chapter 6), although there is some blurring among interpretations. Donagan's formulation more closely follows deontology's format: "It is impermissible not to respect every human being, oneself or any other, as a rational creature".[105] According to many deontologists, including Fried and Donagan, part of respecting others as rational creatures is that one should refrain from subjecting them to the sorts of treatment proscribed by deontological constraints; indeed this is framed as a moral requirement.

Nagel goes further on the above point. In his view, if one identifies certain sorts of conduct as evil - for example, harming a child so that her frightened babysitter reveals some piece of important, perhaps life-saving, information – then it is clear that this conduct is something that one must not do. According to Nagel, 'evil' conduct means that one should be moved to eliminate it rather than maintain it. He believes that if consequentialists allow that it is right to lie to or harm the innocent, then they have an unsatisfactory understanding of what evil means or what it is for someone to be evil. Furthermore, this is true even if the desire and intention is to prevent greater harm or promote the greater good.

Davis claims that none of the aforementioned sources – moral intuitions, religion, or the principle of respect for persons - satisfactorily grounds deontological moral judgements; likewise Hursthouse believes that 'intuition' and 'perception' are "entirely unsatisfactory notions".[106] For example, take appeals to common morality. The picture of the universe, once thought true by the Church Fathers, is now widely rejected. It is now widely thought that the views of priests and monks that dominated early religious morality are punitive or prejudiced. Therefore, as Davis warns,

> If traditional common morality can easily be seen to have such weak parts, it is wise to be sceptical, or at least cautious, about other parts, and about the foundation that holds all the parts together.[107]

## Problems with deontology

### No action guidance until its second premise

Hursthouse has examined the first and second premise of simple deontology (the kind of deontology known to many people, loaded with moral rules). She argues that, as in act-consequentialism, it is not until the second premise of deontology that people are given specific action guidance. In the second premise one is given information on what counts as a correct moral principle, rule, or duty (these three notions forge the link with right action in the first premise). As Hursthouse explains, there are several possible ways in which to describe a correct moral rule or principle, for example, it is one that "is laid down on us by God"... "is universalizable"... [or] "would be the object of choice of all rational beings".[108] Deontologists will defend and justify those rules that they believe are correct, for example, they might defend rules permitting or prohibiting euthanasia, coercion, or suicide. But what does this turn on? The answer to this is not forthcoming.

Moreover, Hursthouse believes that in many versions of deontology, it is untrue to say they "'begin with' the Right, for they [as noted above] use the concept of moral rule or principle to specify right action".[109] Hursthouse notes that Frankena discusses versions of what he calls 'extreme act-deontology' wherein a right action "just *is* right".[110]

Hursthouse believes that in deontology, as in consequentialism, one is so familiar with the moral obligations, rules, or principles proposed. This familiarity grounds one's understanding of the content of the obligations, rules, and principles given in the second premise of deontology. Furthermore, one has a good idea what a correct moral principle or rule is; for, when this premise is given, we have in mind, say, 'do not kill', 'do not break promises' and 'tell the truth'. But Hursthouse thinks one would be

surprised to find contenders such as "'Purify the Arian race', 'Keep women in their proper place, subordinate to men', 'Kill the infidel'".[111] However, as she points out, these have at some point in time all unfortunately counted as 'correct' moral rules. In sum then, given the first premise of a simple yet common form of deontology, one is not actually told what is to count as a correct moral obligation, rule, or principle. But familiarity with what one believes a correct moral rule is fills in the blanks.

**Wrongful harming or the permissible causing of harm?**

People have views about what sorts of acts are right and wrong, and beliefs regarding the limits and bounds of peoples' moral responsibilities for their deeds. These help us to determine whether an act that causes harm is viewed as a case of wrongful harming or merely the permissible causing of harm. Individuals' different normative moral views - about what one should do and how one should live - lead them to have different beliefs about this distinction. Thus, one who is swayed by consequentialism

> will see a refusal to lie to one person in order to prevent serious harm from befalling five other people as a case of wrongfully harming the five, while someone with less consequentialist leanings might not.[112]

Either way, when individuals try to follow deontological views – for example, 'avoid wrongful harming' – they will interpret these views differently and, as a result, probably end up acting in different ways in their attempts to follow such guidelines.

**Appealing to the notion of respect**

It is also prudent to be cautious about appealing to a fundamental moral principle, such as, respect for persons. The notion of respect commonly employed is far from transparent; indeed it appears that the conception of 'respect' or 'respect for rational persons' is used in a narrow, technical or legal sense. Moreover, this idea is not clarified when one talks about respecting persons as rational creatures.

A lack of clarity also surrounds another feature of respect. The requirement of respect, according to deontological views, is thought not to include "respect for other beings as possessors of welfare".[113] The reason for this omission is unclear. Remember that, according to deontological theories, one ought to allow five people to be killed by a rockslide rather than harm one person ourselves. But surely this entails serious disrespect for the lives of the five? It is hard to defend the technical, narrow account usually given to respect. Even if plausible defences of this account could be provided, Davis thinks another important question remains, "why should respect be seen as something that morally outweighs the requirement to further others' well-being?"[114] In other words, why does the obligation of beneficence usually rank lower than respect for other people?

Consequentialists frequently come under attack for maintaining that "as long as human beings can remain alive, the lesser of two evils is always to be chosen...."[115] In their defence, consequentialists claim that minimum conditions must be met for a life worthy of a human and these conditions cannot be sacrificed. While this consequentialist position is open to criticism, it is quite clear that deontologists fare little better. The deontological position maintains, for example, that the whole community should die rather than violate the deontological constraint 'refrain from killing the innocent'. Davis suggests that deontologists need to reflect on the reasoning behind the following scenario,

> a proposed effort to save hundreds of lives by (for example) killing one innocent person that constitutes a failure of respect so great that it is worth sacrificing all of those lives.[116]

The reasoning behind the above scenario appears to make little sense; at least it counters deep moral convictions relating to the human need, and moral responsibility, for saving lives and generally promoting others' interests.

**Criticisms of the doctrine of double effect and the distinction between intended and foreseen harm**

Criticisms have been levelled at the principle of double effect and questions raised over the tenability of the distinction between intended and foreseen harm. These criticisms possess some merit, and as such, create problems for contemporary deontology. In response, deontologists will either need to expand the scope of their prohibitions or they will need to admit that these prohibitions do not carry absolute or categorical force. However, if the first point is addressed then serious problems relating to conflicts between duties arise. And if the second point is tackled, then the very structure of deontological views is threatened, because if deontological constraints do not produce absolute or categorical force, then what sort of force do they possess? How would a person tell between a forbidden act and one that is not? When the absolute force is removed from deontological constraints, then deontological views collapse into a type of moral pluralism, or even worse, an intuitionist type of moral pluralism.

However, according to Fried, deontologists do not believe it is justifiable to refuse to violate a deontological constraint when the consequences of such a refusal would be dire. On such extreme cases, Fried says

> And so the catastrophic may cause the absoluteness of right and wrong to yield, but even then it would be a non sequitur to argue (as consequentialists are fond of doing) that this proves that judgements of right and wrong are always a matter of degree, depending on the relative goods to be attained and harms to be avoided. I believe, on the contrary, that the concept of the catastrophic is a distinct concept just because it identifies the extreme situations in which the usual categories of judgment (including the categories of right and wrong) no longer apply.[117]

But while allowing the violation of deontological constraints in extreme circumstances helps to prevent deontology from fanaticism, it also undermines it as a plausible moral theory. Adding a so-called 'catastrophe clause' is particularly problematic. How does

one goes about distinguishing a 'catastrophic' situation, one in which right and wrong no longer apply, from one which is only deemed 'dreadful', where right and wrong do apply? I share Davis' concern with this arbitrary decision. In extreme circumstances or not, these decisions remain moral decisions. Terrible circumstances do not, according to Davis, relieve us of our obligation to act morally; indeed one could suggest that terrible situations demand more from people, but whether this is framed in terms of duties or obligations or the exercise of virtues is another quite different matter. The idea that the notions of right and wrong are somehow not applicable in dire circumstances is one that Davis believes "encourages complacency...It is one that any reasonable person ought to reject".[118] I concur with the reasoning. But I suggest (from chapter 4 onwards) that one can also view morality in terms of acting well, that is, exercising the virtues, for example, being a kind, patient, and just person. Or conversely, one can act badly, that is, exercise the vices, for example, being a cruel, impatient, and unjust person.

**Criticisms of deontology's rules**

Hursthouse criticises the rules of simple deontology. Three points are made. First, as noted, the rules of consequentialism are, in part, based on several evaluative concepts, for example, happiness. The rules of deontology, for example on lying, are also evaluative, and as such limit their ability to provide adequate action guidance. Deontologists might try to claim that their rules are somehow empirical or non-evaluative, but Hursthouse[119] believes this would be a mistake. This is because most deontologists are keen to invoke principles of beneficence and non-maleficence. And as Hursthouse claims, these moral principles also rest on fairly evaluative concepts, such as, 'promote the *interests* of clients' and 'do no *harm* to clients'.

Second, adult deontologists need to think very hard about what constitutes 'promoting their well-being', 'respecting their autonomy' and 'harming someone'. This point was

made earlier in relation to the evaluative terms involved, but now it is made in relation to the need to exercise judgement. Children in general, Hursthouse notes, have a poor grasp of these sorts of terms, and parents have to work hard to improve their understanding of these complex and vague terms.

Third, so-called 'mother's-knee' rules, for example, 'Don't lie' and 'Keep promises', are only easy to apply when the cases are easy to resolve. Once the cases become hard, so too does the understanding and application of the rules. Once again judgment is involved as is "a grasp of such things as 'the sort of promise that may be broken, or need not be kept, or (even) should not be kept and should never have been made'".[120]

**Moral and legal rights: a critique**

I shall now briefly describe and critique the notions of rights. I have not debated rights-based moral theories[121] in this thesis. This might be criticised because in general ethics, health care generally, and especially in adult and mental health nursing, there is widespread focus and attention on rights, both moral and legal.[122]

Like many other notions and concepts in ethics - for example, the notion of 'best interests' - the notion of rights is portrayed as simple, yet is complex. The notion of rights is a relatively recent idea. It is thought that rights emerged during the Enlightenment, crudely the period of history between the 16th and 18th centuries. Moral rights, as they were conceived, were seen as a means of providing and protecting certain important liberties, such as rights to freedom and preservation of life.

Nowadays, both moral and legal rights are acknowledged, especially in contemporary health care. The latter, for example, patients' rights to refuse treatment, are grounded in common law. But moral rights, for example, to be respected as a rational person, are grounded in moral values and beliefs, which clearly are subjective and personal

notions. Numerous moral and legal rights compete against each other. Thus, as noted by Hare earlier in this Chapter, conflicts between rights arise; these conflicts can be between two or more moral rights as well as moral and legal rights. However, it is not clear how to resolve these conflicts; indeed, it is not clear how one can *know* which rights one has and in what circumstances these can be overridden.

I have five concerns with the notion of rights, which I shall now describe.

First, in ethics one is concerned with moral, not legal, rights and this fact is often overlooked. As noted, legal rights are encapsulated in common or statute law. Usually legal rights in health care are grounded in common law. Moral rights are not synonymous with legal rights. This fact needs recognition. Second, a deeper examination is required on the origin and intended purpose of moral rights. For example, where do rights come from? Are they entitlements to certain things (for example, health care), liberties (for example, freedom), or generally claims for protection? [123] Third, I suggest that when rights are invoked, for example in terms of justice, one needs to bear in mind one's corresponding moral responsibilities. For instance, if one has a moral right to have a coronary artery bypass operation, then one has a moral responsibility to ensure that both pre and post operatively one does everything possible to make the surgery successful. This might include stopping smoking before the operation. These corresponding moral responsibilities are fraught with tensions and are often neglected in discussions about rights. Fourth, another aspect of rights that causes me concern is the seemingly endless lists that are nowadays produced from people who want certain protections or feel entitled to x or y. For example, 'I surely have a right to smoke a cigarette in public' or 'I have a right to park my car in this space even though it's for a disabled person'. These are examples where one's corresponding responsibilities have been disregarded. Possessing rights

should mean that one behaves *decently* in return, meaning that the needs and interests of other people should be taken into account.

To close this section, I believe it is not so much the moral right in question that is problematic, as long as the right can be adequately justified (however, this is not always done nor is it easy to do). Rather, it is the manner in which people exercise 'their' rights that I find objectionable. From a virtue ethics perspective, moral rights can be exercised either virtuously (for instance, kindly) or viciously (for instance, cruelly). How other people respond to peoples' requests or *demands* for their perceived moral rights is of fundamental importance in morality. It seems to me that if one requests and exercises rights kindly or justly, then this serves as an illustration of that person acting morally well or being morally good. The virtues of justice and respectfulness should maintain that justifiable moral and legal rights are not, without good reasons, overridden.

**Deontology and intuitions: a response**

Before I conclude this chapter, I shall discuss a possible response from deontologists with regard to their dependence upon intuition, to discover whether they can overcome this problem.

This dependence upon intuition is denied, at least by some deontologists, in an attempt to respond to this standard objection. These deontologists advocate the 'strong codifiability thesis' noted earlier by Hursthouse. In her words,

> They suppose (a) that they have (or will be able to formulate in time) a complete and consistent set of rules in which second-order ranking rules or principles settle any conflicts among first-order rules, which have been formed with much more precision than the 'mother's-knee' versions, and which may also be supposed to have had many necessary exception clauses built into them. Such a system would determine what was required in every situation and (b) would not rely on intuition or insight to resolve conflicts.[124]

If the above albeit extravagant strategy is accepted, then it would appear that deontology could solve the conflict problem without dependence upon intuition or perception.

But Hursthouse believes that such deontologists have a particular conception of what counts as an adequate normative ethics, namely one that provides adequate action guidance. These deontologists hold that an adequate moral theory is one "that yields a decision procedure which can be used to resolve conflicts or settle moral quandaries without recourse to moral wisdom".[125] Act utilitarians, as noted, argue that their theory with its single rule provides just such a decision procedure. If one wants a moral theory that prescribes right action and ignores other morally important features, then act-utilitarianism is one to take seriously.

On the 'strong codifiability thesis', O'Neill describes it as "an algorithm not just for some situations but for life".[126] But Hursthouse believes there are deontologists who for one reason or another do not accept this algorithm as an appropriate test of adequacy. Kantians would probably reject it since, as O'Neill claims, Kant denies the possibility of such an algorithm. According to O'Neill, Kant held that "every application of a rule would itself need supplementing with further rules".[127] Other non-Kantian deontologists claim that the ability to recognise the morally important features of a concrete situation requires not only judgement but also "'moral sensitivity, perception, [and] imagination'.[128] This, according to Hursthouse, *is* moral wisdom. The result in the end is a division of opinion about the meaning of adequacy in relation to moral theories. For example, for utilitarians an adequate normative ethics must provide an adequate decision procedure, while there is much disagreement on this by deontologists.

### Deontology: conclusions

I have noted several objections with deontological views that provide cause for concern. These include problems with the narrow framing and direction of deontological constraints, the lack of specific action guidance until deontology's second premise (despite an assumption to the contrary), a lack of clarity regarding the distinction between intended and foreseen harm, problems with the nature and content of deontology's rules and problems inherent in relying on intuition for resolving the ranking of obligations, rules or principles.

## Conclusions

I have examined forms of consequentialism and deontology and noted some of the common objections levelled at these theories. Consequentialism makes the notion of the Right prior to the notion of the Good, while deontology views morality the other way around. However, both kinds of theory *over* focus on the role of moral obligations, rules, and principles in morality. The notions of permission, prohibition and the aim to prescribe right action are held to be extremely important. To this end, decision procedures are produced to resolve dilemmas. Both kinds of theory make assumptions about the nature of moral dilemmas, for instance, that they are *always* resolvable. Furthermore, the notion of moral remainder discussed by Hursthouse is a very important topic. While there is intrinsically nothing about obligation-based theories that precludes discussing the role of emotions and feelings in morality, this does not appear to be acknowledged in the literature. Obligation-based ethical theories are incomplete, for example, the theories discussed in this chapter omit to provide a satisfactorily rich and textured account of peoples' moral character. Alongside thinkers such as Rachels and Williams, I believe that incomplete moral theories are therefore inadequate.

# REFERENCES AND ENDNOTES

[1] 'Act-centred' is often used instead of 'obligation-based', for example by R. Hursthouse, *On Virtue Ethics* (Oxford: Oxford University Press, 1999). These terms are interchangeable and commonly used as such in the literature. I shall use 'obligation-based' because it makes clear that the philosophical foundation for one's acts are obligations, and in ethics one is concerned with moral obligations (rather than legal or professional obligations).

[2] I take the meaning of 'ethics' and 'moral' to be, for the purpose of this thesis, synonymous. I am aware that the origin of 'ethics' is Greek, from *ethos* meaning custom, and the origin of 'morals' is Latin, from *moralis* meaning good behaviour. I use moral to achieve consistency as both the virtues and obligations are referred to using 'moral' and not 'ethical'.

[3] In this thesis, unless I need to make a comparison or explain a point of contrast, I use 'moral obligations' to mean all three notions.

[4] This is of course too crude a description, but it makes an accurate point. However, there are many various conceptions of obligation-based ethics, for example, some focus on moral rules and object to moral obligations *per se*, others rely heavily on certain strict *prima facie* obligations, and as is common with moral theories, some versions are strict, others moderate and yet others expressed in weak forms.

[5] Kantianism (or Kantian ethics) is not featured in this chapter as a particular, extreme form of deontology. Although it is clearly based on Kant's ethics, differences do exist. Indeed, the distinction between Kant's ethics, Kants' ethics and Kantian ethics is the object of a large body of literature, see for example, O. O'Neill, "Kant's Ethics" in *A Companion to Ethics* ed. P. Singer (Oxford: Blackwells, 1991), pp. 175-185. Crudely, Kantianism is a moral theory that claims that the morality of an act has nothing at all to do with its consequences; it all comes down to the nature of the act itself. Kantians accept several of Kant's claims regarding human morality. For example, the prime role of 'reason' in the lives of people, the range of perfect and imperfect duties people owe to others, and the importance of imperatives, including hypothetical and categorical, in the moral lives of people.

[6] Henceforth, I use only 'consequences' for brevity.

[7] R. G. Frey talks about act-utilitarianism and act-consequentialism, but makes it clear that these are interchangeable and represent the same theory, see R., G., Frey, "Act-utilitarianism" in *Moral Theory* ed. H. LaFollette (Oxford: Blackwell Publishers, 2000), pp. 165-182.

[8] Frey, "Act-utilitarianism", p. 165.

[9] J. Glover, *Causing Death and Saving Lives* (Harmondsworth: Penguin, 1977), p. 3.

[10] Frey, "Act-utilitarianism", p. 165.

[11] Ibid.

[12] J. Griffin, *Wellbeing* (Oxford: Clarendon Press, 1986).

[13] Frey, "Act-utilitarianism", p. 165.

[14] For a discussion of value theory, including desire accounts of value, and the Best Interests Standard used in health care ethics see: D. DeGrazia, "Value theory and the best interests standard", *Bioethics* **9** (1), 1995, pp. 50-61.

[15] M. Slote, *Beyond Optimizing* (Cambridge, Mass.: Harvard University Press, 1989).

[16] R., M. Hare, *Moral Thinking* (Oxford: Oxford University Press, 1981).

[17] J., S. Mill, "Utilitarianism" in *Classics of Western Philosophy* ed. S., M. Cahn (Indianapolis: Hackett Publishing Group, Inc., 1990), pp.1063-1114, p. 1066-1067.

[18] J. Rachels, *The Elements of Moral Philosophy,* 3rd ed. (New York: McGraw-Hill, 1999), p.189.

[19] B. Williams, *Ethics and the Limits of Philosophy* (Cambridge, Mass.: Harvard University Press, 1985); B. Williams, *Making Sense of Humanity* (Cambridge: Cambridge University Press, 1995).

[20] R. Hursthouse, *On Virtue Ethics* (Oxford: Oxford University Press, 1999), p.44.

[21] Ibid.

[22] Hursthouse, *On Virtue Ethics*, p.45.

[23] Ibid.

[24] Ibid.

[25] Ibid.

[26] Hursthouse, *On Virtue Ethics*, p. 46.

[27] Ibid.

[28] Ibid.

[29] Ibid.

[30] Ibid.

[31] Ibid.

[32] Hursthouse, *On Virtue Ethics*, p. 47.

[33] Ibid.

[34] Ibid.

[35] ibid.

[36] Hursthouse, *On Virtue Ethics*, p. 26.

[37] Hursthouse, *On Virtue Ethics*, p. 27.

[38] Hursthouse, *On Virtue Ethics*, p. 31.

[39] Hursthouse, *On Virtue Ethics*, p. 55.

[40] Ibid.

[41] Ibid.

[42] Ibid.

[43] M. Stocker, "The Schizophrenia of Modern Ethical Theories" in *Virtue Ethics* eds. R. Crisp & M. Slote (Oxford: Oxford University Press, 1997), pp.66-78.

[44] Stocker, "The Schizophrenia of Modern Ethical Theories", p.74.

[45] Ibid.

[46] Frey, "Act-utilitarianism", p. 166.

[47] Ibid.

[48] M. Slote, *From Morality to Virtue* (New York: Oxford University Press, 1992).

[49] J. S Mill, "Utilitarianism", ed. R. Crisp in *Utilitarianism* (Oxford: Oxford University Press, 1998).

[50] Rachels, *The Elements of Moral Philosophy,* p. 18.

[51] Ibid.

[52] The charge that act-consequentialism produces conflicts and clashes with at least some of our moral intuitions, though standard since Hare's 1981 *Moral Thinking*, remains unsettled. Thus the question of moral intuitions possessing probative force (that is, the ability to prove x or y) in ethics also remains disputed. It is perhaps doubtful whether any moral feature has the ability or otherwise to prove x or y. Morality is not definable by empirical facts, unlike the humans sciences. This is a crude claim and it raises complex, but crucial epistemological issues and questions that require scrutiny. Much depends upon whether one is an advocate of moral realism or not, but even this apparently simple division is not as simple as it might appear.

[53] J. Rawls, *A Theory of Justice* (Cambridge, Mass.: Harvard University Press, 1971).

[54] Frey, "Act-utilitarianism", p. 167.

[55] H. Sidgwick, *The Methods of Ethics* (London: MacMillan, 1962).

[56] J., J., C. Smart, "An outline of a system of utilitarian ethics" in *Utilitarianism For and Against* (Cambridge: Cambridge University Press, 1973), pp. 3-67.

[57] E. Pincoffs, "Quandary Ethics" in *Ethical Theory 2 – Theories about how we should live* ed. J. Rachels (New York: Oxford University Press, 1998), pp187-205.

[58] Hursthouse, *On Virtue Ethics*, pp. 39-40.

[59] Frey, "Act-consequentialism", p. 168.

[60] D. Lyons, *Forms and Limits of Utilitarianism* (Oxford: Oxford University Press, 1965).

[61] "Rule Utilitarianism" in *The Internet Encyclopedia of Philosophy* (author unknown), www.utm.edu/research/iep/r/ruleutil.htm, accessed 12/1/02.

[62] See R., M., Hare, *Moral Thinking,* (Oxford: Oxford University Press, 1981); R., M., Hare "The philosophical basis of psychiatric ethics" in *Psychiatric Ethics* eds. S. Bloch & P. Chodoff (Oxford: Oxford University Press, 1991), pp. 33-46.

[63] Hare, "The philosophical basis of psychiatric ethics", p. 33.

[64] Ibid.

[65] Hare, "The philosophical basis of psychiatric ethics", p. 35.

[66] Hare, "The philosophical basis of psychiatric ethics", p. 35.

[67] G. Dworkin, "Paternalism" in *Morality and the Law* ed. R. Wasserstrom (Belmont: Wadsworth, 1971), pp. 107-126; G. Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988).

[68] Hare, "The philosophical basis of psychiatric ethics", p. 35.

[69] Hare, "The philosophical basis of psychiatric ethics", p. 37.

[70] Hare, "The philosophical basis of psychiatric ethics", p. 38.

[71] Hare, "The philosophical basis of psychiatric ethics", p. 40.

[72] Hare, "The philosophical basis of psychiatric ethics", p. 42.

[73] Hare, "The philosophical basis of psychiatric ethics", p. 44.

[74] Hare, "The philosophical basis of psychiatric ethics", p. 44.

[75] Hare, "The philosophical basis of psychiatric ethics", p. 45.

[76] Frey, "Act-consequentialism", p. 169.

[77] Frey, "Act-consequentialism", p. 176.

[78] 'Deontology' derives from the Greek '*deon*' translated as 'duty'.

[79] I. Kant, *The Metaphysics of Morals* trans. M., J. Gregor (Cambridge: Cambridge University Press, 1991).

[80] W., D. Ross, *The Right and the Good* (Oxford: Clarendon Press, 1930).

[81] This section is based on: Nancy (Ann) Davis, "Contemporary Deontology" in *A Companion to Ethics* ed. P. Singer (Oxford: Blackwell Publishers, 1990), pp. 205-218.
[82] Davis, "Contemporary Deontology", p. 205.

[83] J. Rawls, *A Theory of Justice* (Cambridge, Mass.: Harvard University Press, 1971), p.24.

[84] J. Rawls, *A Theory of Justice*, p. 30.

[85] J. Rawls, *A Theory of Justice*, p. 30.

[86] C. Fried, *Right and Wrong* (Cambridge, Mass.: Harvard University Press, 1978), p. 9.

[87] Davis, "Contemporary Deontology", p. 206.

[88] Davis, "Contemporary Deontology", pp. 206-207.

[89] Davis, "Contemporary Deontology", p. 207.

[90] Ibid.

[91] I made this point earlier in the section on 'Consequentialism'.

[92] Davis, "Contemporary Deontology", p. 207.

[93] Ibid.

[94] Fried, *Right and Wrong*, pp. 9-10.

[95] This is one strand of thought debated by moral particularism and universalism.

[96] T. Nagel, *The View From Nowhere* (New York: Oxford University Press, 1986), p. 177.

[97] Davis, "Contemporary Deontology", p. 209.

[98] Ibid.

[99] Fried, *Right and Wrong*, p. 13.

[100] Ibid.

[101] Davis, "Contemporary Deontology", p. 209.

[102] Nagel, *The View From Nowhere*, p. 179.

[103] Davis, "Contemporary Deontology", p. 210.

[104] Nagel, *The View From Nowhere*, p. 176.

[105] A. Donagan, *The Theory of Morality* (Chicago: University of Chicago Press, 1977), p. 66.

[106] Hursthouse, *On Virtue Ethics*, p. 53.

[107] Davis, "Contemporary Deontology", p. 212.

[108] Hursthouse, *On Virtue Ethics*, p. 27.

[109] Ibid.

[110] W. Frankena, "Ethics" (NJ., USA : Prentice Hall, 1973) cited in R. Hursthouse, *On Virtue Ethics*, p. 27.

[111] Hursthouse, *On Virtue Ethics*, p. 31.

[112] Ibid.

[113] Davis, "Contemporary Deontology", p. 213.

[114] Ibid.

[115] Donagan, *The Theory of Morality*, p. 183.

[116] Davis, "Contemporary Deontology", p. 213.

[117] Fried, *Right and Wrong*, p. 10.

[118] Davis, "Contemporary Deontology", p. 216.

[119] Hursthouse, *On Virtue Ethics*, p. 33.

[120] Hursthouse, *On Virtue Ethics*, p.62.

[121] See: B. Almond, "Rights" in *A Companion to Ethics* ed. P. Singer (Oxford: Blackwells, 1991), pp. 259-269; L. Sumner, *The Moral Foundation of Rights* (Oxford: Clarendon Press, 1987).

[122] See: Department of Health, *The Patients Charter* (London: DoH, 1992); Department of Health, *The Patients Charter and You* (London: DoH, 1999); Nursing & Midwifery Council, *Code of Professional Conduct* (London: NMC, 2002); Department of Health, *The Human Rights Act* (London: DoH, 1998).

[123] P. Jones, *Rights* (London: Macmillan, 1994).

[124] Hursthouse, *On Virtue Ethics*, pp. 53-54.

[125] Hursthouse, *On Virtue Ethics*, p. 54.

[126] O. O'Neill, "Abstraction, Idealization and Ideology in Ethics (Cambridge: Cambridge University Press, 1987) cited in R. Hursthouse, *On Virtue Ethics*, p. 54.

[127] Ibid.

[128] S. Scheffler, "Human Morality" (Oxford: Oxford University Press, 1992, p. 43) cited in R. Hursthouse, *On Virtue Ethics*, p. 54.

# CHAPTER 5 – THE ORIGINS, DEVELOPMENT AND TENETS OF VIRTUE ETHICS

## Introduction

I have established the importance of interpersonal responses to the end of being a 'good' nurse. Certain personal qualities such as kindness and honesty are deemed to be crucial to developing a therapeutic relationship between nurses and patients. These qualities are moral virtues. I have rejected the plausibility of obligation-based moral theories in general ethics. I shall now examine the moral theory that makes the virtues central to morality, namely virtue ethics.

In this Chapter, I trace the origins and development of virtue ethics. I identify 3 main tenets of virtue ethics. I note the distinction between supplementary and strong forms. I examine Aristotle's virtue ethics. I look more closely at virtue ethics' account of moral character and moral education. I then examine recent work by Hursthouse on virtue ethics' account of action guidance. I note some common objections towards virtue ethics. I end this Chapter by claiming that good reasons exist for strong virtue ethics being plausible.

## The characterization of moral theories

Characterizing moral theories is fraught with dangers. It is not easy to adequately explicate key aspects of complex theories so that both generalists can understand what the theory is about - its central tenets - and specialists can understand the theory's subtleties and distinctions. Inevitably certain aspects of the theory in question will be either omitted (often the more complex ideas) and other parts will receive repeated attention (often the more manageable ideas). It is fair to say that all moral theories have been the

victims of this tactic. However, it is unreasonable to expect an ethicist to have specialist knowledge of all moral theories; this is why theorists specialize in one type of theory in the first place. But perhaps because of this fact, it is necessary to realize that moral theories are often characterized with the use of slogans.[1] For example, act-consequentialism is known as 'maximize the acts with the best consequences' and deontology is known as 'act in accordance with these moral rules...'

**The origins and development of virtue ethics**

As noted in Chapter 3, ancient Greek philosophy, including the pre-Socratics but principally Socrates, Plato, and Aristotle, focused on the notions of the good life for man, human nature, and as a requirement of these, the virtues. Despite a few moral philosophers, such as Aquinas and Hume, acknowledging the importance of the virtues in morality, virtue ethics as a moral theory was not realized until its recent revival.

Anscombe[2] in 1958 is recognized as initiating virtue ethics' revival. Virtue ethics now joins consequentialism (including utilitarianism) and deontology as an alternative moral theory. Anscombe argued that modern moral philosophy was bankrupt and misguided. She claimed that modern moral philosophy was grounded in the incoherent notion of a law, without a lawgiver. To virtue ethicists, this idea now makes no sense; neither do the related notions of obligation, duty, rightness and wrongness. Anscombe urged us to jettison the notions of 'right action' and 'morally right action', indeed the entire class of deontic (duty-based) notions. Things would be improved, she claimed, if such notions were no longer used. Conduct in general, or a particular act, could still be assessed but different aretaic (virtue and vice) terms would be used, for example, 'dishonest', 'fair', 'kind', and 'unjust'. Instead of this flawed preoccupation with deontic theories and notions,

Anscombe urged us to return to Aristotelian ethics. For her, the virtues should once again be the focus of ethics.

**What do other moral theories say about the virtues?**

Kantians[3] claim that virtuous people are more likely to possess the moral character that disposes them to act according to universal moral principles and laws. For utiltiarians, such as J S Mill[4], people who possess the virtues tend to carry out those acts that maximise happiness and minimise suffering. For this reason, consequentialists advocate that people should cultivate virtue. However, one can see that within obligation-based ethics the value of the virtues is still seen in terms of acting in accordance with moral rules, obligations, and principles or producing good consequences.

**The central tenets of virtue ethics**

Critics allege that there is no such thing as a theory of virtue, meaning that all of the versions of virtue ethics are distinct and different. According to Rachels, there is "no settled body of doctrine on which all these writers agree". [5] In its defence, the revival of virtue ethics started quite recently and compared with obligation-based moral theories, virtue ethics is an immature, underdeveloped theory. In time with more scholarly interest and work, virtue ethics will, I think, clarify and refine its position. Furthermore, the above criticism can also be levelled at the many distinct versions of obligation-based moral theories. What is not in doubt, however, is that versions of virtue ethics share a set of concerns, which, as noted, are largely ignored in obligation-based ethics. I shall use the term 'tenet', because these concerns mark out virtue ethics as a distinct moral theory and a credible alternative to consequentialism and deontology. I shall list 3 central tenets of virtue ethics:

1. A desire to provide a detailed account of persons' moral character;

2. A reluctance to fully endorse, or a rejection of, the assumption that moral theories *necessarily* have to provide an account of right action in terms of obligations;
3. A desire to provide a plausible account of moral education – for example, how can adults best teach children to be moral agents?

To this list, I would add that virtue ethics aims to provide persons with a more natural and convincing account of moral motivation, compared with the unsatisfactory account given by consequentialism and deontology (as discussed in Chapter 4). I shall examine moral motives in this Chapter and again in Chapter 7 in relation to virtue-based moral decision-making in nursing practice.

There are several aspects of morality that, while not explicitly linked to virtue ethics, have developed, in part, from examining the aims of moral theories and specifically, the notions of, and relationship between, 'right action' and 'good character'. An example of this is Hursthouse's claims in relation to moral dilemmas (discussed in Chapter 3). First, one should not assume that dilemmas are resolvable. Second, many dilemmas turn out to be 'irresolvable' or 'tragic'. In all three types of dilemmas, it is morally appropriate for a person to feel moral remainder. This refers to feelings and emotions, such as, distress, remorse, guilt, and regret that a person feels during and after one's involvement in horrible situations, which one did not wish to be involved in.

Moral remainder particularly applies to irresolvable and tragic dilemmas, because the hurt and damage to persons' lives is much more intense. Partly, as a consequence of Hursthouse's claims and partly because of virtue ethics' focus on the virtues and vices and the importance of such things as human responsiveness and relationships, it seems to me that virtue ethics makes much more room for the role of feelings and emotions in the moral

life. Compare this to the obligation-based view, as exemplified by Kant, Kantian ethics, and other forms of deontology that views emotions as subjective and personal phenomena and therefore have no place in objective rule and duty based ethics.

### Virtue ethics: nomenclature

One may distinguish between supplementary and strong[6] (also called radical or free-standing) theories.

### Supplementary virtue ethics

Supplementary theories view the virtues and a corresponding virtue ethics as requiring assistance from a version of obligation-based moral theories. This approach (also known as essentialism[7]) combines an account of right action provided by obligation-based ethics, for example, consequentialism or deontology, with an emphasis on moral character provided by the virtues and virtue ethics. The account of the virtues is offered as a supplement to an obligation-based theory of right action. Rachels[8] believes that this approach has much to recommend it.

#### Supplementary virtue ethics: weak and moderate versions

Supplementary versions of virtue ethics can be further subdivided into those that hold that (a) obligations and right action are more important than the virtues and moral character in morality or that (b) the virtues and moral character are more important in morality than obligations and right action. The former can be called 'weak' and the latter 'moderate' versions of virtue ethics. In weak versions, the claim is that moral character is not as crucial as prescribing right action and persons 'doing the right thing'. So that while the virtues have a role to play in morality, this is thought to be a rather unimportant one. The emphasis on right action and revealing the morally correct decision is one of the core

tenets of obligation-based moral theories. Conversely, moderate versions of virtue ethics view morality the other way around. Moderate versions believe that moral character takes precedence over right action. Therefore, it is more important for people to cultivate and exercise the virtues, thus taking care of moral character, rather than focusing on the idea of 'doing the right thing'; although the latter is where moral obligations remain implicated.

Regarding the 'virtues as needs' claim made in Chapter 3, would there be differences between weak and moderate supplementary theorists? Take weak theorists first. Their position would be along the lines of 'well, yes, it would be a good thing if agents cultivated the virtues, but I prefer to think we're obliged to do this, although morality would remain in pretty good shape without everyone possessing the virtues'. But the moderate theorist would go further and claim that good moral character needs the virtues (although some might think this should still be framed as a moral obligation).

**Supplementary virtue ethics in medicine: Pellegrino and Thomasma**

Pellegrino and Thomasma's version of virtue ethics in medicine is a supplementary theory. It is clear that they regard moral principles as possessing greater moral force than the virtues. Moral obligations are certainly held to be important to the moral conduct of physicians. Without such duties, virtue ethics is left unable to adequately prescribe action-guidance for physicians. So physicians might display the virtues - be of good character, for instance, be honest, just, and compassionate - and yet they still might end up doing wrong actions. Pellegrino and Thomasma see a strong link between moral principles and corresponding virtues, each supplementing and informing the other.[9]

### Supplementary virtue ethics in nursing

Brody[10] published an influential article in 1988 in which she examined the supplementary role of caring and the virtues in adult nursing; I believe this is a moderate version of virtue ethics. Examples of supplementary virtue ethics in mental health nursing are those of Lutzen and Barbosa da Silva[11] and McKie and Swinton.[12] I do not discuss the latter. But I note that while it is steeped in Aristotle and pays homage to MacIntyre, both of whom advocate a strong virtue ethics, MacKie and Swinton's conception remains supplementary, albeit one that is perhaps moderate in terms of how important the authors view the virtues.

#### Lutzen and Barbosa da Silva's virtue ethics

Lutzen and Barbosa da Silva discuss the concept of virtue and the role of virtue ethics, as a necessary but insufficient complement to rule based ethics in psychiatric nursing. As well as ethical principles and rules, they claim that an emphasis needs to be given to relational aspects of nursing, that is, human interactions and the nurse-client relationship. For the authors, moral motivation, which has been largely ignored in traditional obligation-based ethics, is necessary in a moral activity such as nursing,

> virtue ethics serves as a necessary complement in an ethical framework for health care practice with regard to the moral agent as such (the kind of person he/she ought to be) and the motivation for obeying or following a given moral obligation or duty in concrete situations.[13]

The authors argue that virtues enable the nurse to evaluate an ethical dilemma, identify all the morally relevant features and then apply the appropriate ethical rules and principles to the dilemma. Both intellectual and moral virtues are needed "for the realization of various kinds of duties or moral obligations...".[14] Further, it is necessary to have practical wisdom as this allows for the "realization of the other virtues".[15] Teaching the virtues to student nurses involves classroom (theoretical) and clinical environment (practical) teaching, and

of particular importance is the use of good role models. The authors conclude that as well as the theoretical knowledge possessed by the nurse, it is morally necessary to consider "what kind of person one is as a moral agent".[16]

**Criticism of Lutzen and Barbosa da Silva's version**

This supplementary approach has its merits, for example, at least the authors recognize the importance of the virtues in moral decision making in nursing. It is, however, unclear whether the authors would argue for a weak or moderate position. My view is that this version represents a weak version of virtue ethics. Virtue is held to be necessary, but not sufficient to morality in nursing. The authors essentially claim that virtues help to provide the right motivation for the nurse in order to decide which moral rule to obey and follow. The authors clearly believe that in nursing, one needs nursing knowledge, moral principles and rules to make the 'right moral decision' or the 'morally right decision'. But I think that the authors are confusing two ways in which these terms can be used, which Hursthouse notes (this was explained in Chapter 3). I shall present a clinical situation that will be used to bring out this confusion: Mary, a 65-year-old female, diagnosed with a primary endogenous major depressive disorder, has had ECT with good results in the past. On this occasion, though, after the first two treatments she refuses to have a third. She is 'reassured' into having another treatment by the charge nurse, despite saying "I don't want another treatment....I'm afraid. Don't make me go". After having this and subsequent treatments, she recovered and was discharged. [17]

Suppose that this is a resolvable dilemma: act x is to coerce Mary to have ECT, while act y is to respect her wish to refuse ECT. It is thought that act x should be carried out because it is more beneficial. This can then be called a 'right moral decision' or the 'morally right decision' given the worse option of y. However, a second way in which these

terms can be used refers to a morally good deed, for example, when a person displays the virtues and performs an admirable act, one that others praise. This meaning cannot be applied to act x – helping to force Mary into having ECT is not a virtuous, morally admirable, or good deed. This confusion is one crucial problem with obligation-based moral theories in general. But it is also, in my view, the flaw in supplementary virtue ethics. I understand the reasons behind ethicists wanting to develop supplementary accounts of virtue ethics. For example, it might be thought that adding in the virtues will ensure that moral character is not neglected. But as long as virtue is conceived primarily in terms of helping persons (nurses) to decide upon which moral obligations, rules, and principles to act on, then introducing the virtues will not reveal the confusion between the two meanings of 'right moral decision/morally right decision'. Irrespective of whether the theory is weak or moderate this confusion will continue. The implication is that the virtues will only be allowed to operate as a necessary component of nursing ethics, as a way of identifying the correct moral rules or principles for use in particular situations. The focus will remain on the first meaning of 'right moral decision/morally right decision'; the second meaning, that is, a morally good, admirable and virtuous deed, will pass without reflection.

**Strong virtue ethics**

Strong versions of virtue ethics (also known as eliminatism[18]) include Aristotle, MacIntyre, and Hursthouse. I shall discuss Aristotle's ethics later in this Chapter. Chapter 8 is devoted to MacIntyre's virtue ethics. Some of Hursthouse's claims were presented in Chapter 3 and 4 and her influence is felt throughout this thesis. These thinkers hold that virtue ethics and the virtues are capable of doing all the work of ethics. Rachels calls this, "an independent theory of ethics that is complete in itself".[19]

For strong virtue ethicists, one's moral character, moral motivations, and the justification of acts is couched solely in the virtues. These ethicists reject the use of 'right' and 'wrong'. They follow Anscombe in wanting to jettison all deontic notions from ethics. Instead, strong virtue ethicists would justify, for instance, not bullying someone, not because it is 'wrong', 'unethical' or 'it breaks the moral rule "do not harm others"' but because 'it is cruel'. Instead of deontic terms, the language of the virtues and vices is employed.

**Aristotle's virtue ethics**

In this section, I examine Aristotle's conception of ethics, drawn from Book 1 and 2 of the *Nicomachean Ethics.* I do so for two reasons. First, Aristotle is a pivotal philosopher in the history of virtue ethics and has influenced several contemporary moral philosophers, including Hursthouse. Second, this section provides the philosophical foundations for Chapter 8 on MacIntyre's virtue ethics, MacIntyre is another philosopher influenced by Aristotle.

**Aristotle on the good life**

It should be remembered that for the ancient Greeks, ethics was valued as one component of politics, so the focus was on the protection of the State. Ancient Greek ethics was not concerned with moral rules or universal principles that aim to instruct people what to do (these notions had not yet been conceptualized). Instead Greek ethics, in general, and Aristotle, in particular, was concerned with questions such as, 'what sort of people do we have to be if we are to live the good life?'

What is this 'good life' that Aristotle made the focus of his ethics? To understand this, one needs to examine Aristotle's account of human nature. The opening words of *The Nicomachean Ethics* are

> Every art and every inquiry, and similarly every action and pursuit, is thought to aim at some good; and for this reason the good has rightly been declared to be that at which all things aim. [20]

It is noted however that some pursuits, for example child abuse, war, and terrorism aim at evil or causing great harm. Despite this Aristotle believed that actions and pursuits aimed at good. One might choose one good, say friendship, over another, say the pleasures of food, where neither holds priority. In this way, it is possible to go on *ad infinitum*. Aristotle thought that there must be a chief good, one that is chosen for its own sake. All moral inquiry sought to investigate the nature of this chief good. For Aristotle, it was important that everyone understood the need to pursue this chief good. In his view, if one needs to ask why, then one has misunderstood the nature of the good.

However Aristotle's argument is circular. He believed that to know what the good consists of, one must have had the 'right' moral education and the 'right' character. In other words, one must be virtuous to know what the good consists of. But presumably one must know what the good consists of to be virtuous.

**Eudaimonia**

For Aristotle, the chief good for man was 'eudaimonia'. There is disagreement over the precise meaning of this term. W D Ross[21] and Benn[22] translate this as 'happiness'. However, others use 'flourishing'. Which term is more appropriate? This is a difficult, and to some extent futile question, because as long as theorists make their conception clear, then mutual understanding should be possible. I shall, however, briefly discuss this notion because it is an important notion in Aristotle and other neo-Aristotelian virtue ethics.

For many 'happiness' conjures up the satisfaction of physical and psychological needs, although some may be more myopic on this, viewing happiness solely in terms of satisfying physical needs. Perhaps 'flourishing' suggests a more overall state of affairs; when one flourishes one fares well and one's life goes well. Perhaps to fare well it is not just needs that need to be satisfied, but the promotion of one's interests too. This description could also apply to well-being, which so many obligation-based ethicists are fond of using, for example, when my interests are promoted then my well-being is promoted too. Happiness and well-being could therefore be synonymous. But is flourishing the same as well-being? Both terms suggest an organism's overall state of harmony. To fare well one's needs and interests need to be met, perhaps flourishing emphasises non-physical needs such as emotional and spiritual needs. This debate could be discussed at length without drawing firm conclusions. However, in relation to the translation of eudamonia, it is plausible to suggest that well-being and happiness are synonymous and that flourishing shares some of these characteristics too.

Benn remarks that eudamonia is not, like euphoria, a psychological state. Instead it refers to one's life faring well. If I am faring well, if my life is going well, then I flourish. Will I always be happy when I flourish? Will there be moments of unhappiness even when I reckon that, on the whole, I am doing well? Of course there will be. A typical day in the life of Robert, the charity worker (Chapter 3), will contain moments of sadness, distress, and unhappiness. Nevertheless, he fares well and succeeds in his role. A connection exists "between feeling happy and having your life go well". [23] But there might be moments when one's life, on the whole, is going well and yet one experiences sadness or misery from a myriad of sources and for many reasons. Given the diversity of human needs and interests there will be "more and less fulfilling ways of going about these things". [24]

However, one is led very sharply into the moral high ground if one attempts to distinguish between these kinds of activities.

In the thesis so far, instead of using the term 'flourishing' I have used the phrases 'to fare well', 'faring well' or 'one's life going well'. These phrases adopt the aretaic (virtue and vice) term 'well' and are thus more accurate in terms of peoples' traits, thoughts and acts. Both 'flourishing' and 'to fare well' form part of a typical conception of flourishing; I refer the reader to philosophical literature on the latter notion.[25] In this Chapter, I use 'flourishing' because this is the usual translation of Aristotle's 'eudamonia'. But in my view 'faring well' and 'flourishing' are equivalent.

**What does flourishing comprise?**

For Aristotle, this concerns the function of the organism or object in question. Everything, whether a spoon, pencil or man had, according to Aristotle, a characteristic function or activity. For instance, the function of a knife is to cut. The *characteristic* function of man, Aristotle thought, cannot be biological living because this applies to a whole range of animals and plants. For such a function or activity to be characteristic of man, it needed to be unique to humans. This turned out to be, in Aristotle's view, the life of reason. In his words, this rational element is

> activity of soul exhibiting excellence, and if there be more than one excellence, in accordance with the best and the most complete.[26]

Man would flourish, according to Aristotle, as long as he met the function of reason. For Aristotle, it was important that man carried out his function, not in any fashion, but excellently, to the best possible extent. But what conception of excellence or good did Aristotle have in mind? On human good Aristotle claimed, "Human good turns out to be an activity of soul exhibiting excellence"[27] (although this actually sounds almost identical to

his definition of reason, above). For Aristotle, every human activity has an appropriate excellence and the aim for man was to carry out these activities in an excellent manner.

**Goodness and function**

For Aristotle there was a tight relationship between being a good person and human function. For a person to flourish, one must live in accordance with the distinctive function of man. As noted, Aristotle believed this was excellence in reason, which can be amended to improve its scope of meaning to 'reasoning and thinking'. Man lived well if he lived according to a rational principle. For Aristotle the best[28] life was one of pure theoretical contemplation, that is, the life of a philosopher. Aristotle believed that the essence of being a good man was his ability to think well. This approach has advantages for the justification of morality, especially the desire to make it more objective. Moral truth becomes a naturalistic truth, in the sense that one can empirically assess (by using the special senses) whether *x* is good or not. One can watch man to see if he is living according to his function. Or one can observe a boat to see whether it moves smoothly over water and floats; if it does, it is a good boat. However, if it sinks in the water then it is not a good boat. This is true even if it looks fabulous; it is not a good boat because it has failed to meet its function. [29]

**The use of 'good'**

The above discussion introduces an important point made by Benn[30] about the use of 'good'. When one considers 'the QE2 was a good ship', one does not mean *both* good *and* a ship. Rather one means 'the QE2 was good *as* a ship'. Further, if one says about Robert, the charity worker, that 'he is a good man' one does not mean *both* good *and* a man, but good *as* a man. This is because goodness is related to the degree that one succeeds in discharging one's function; this suggests a crude form of functionalism.[31]

To speak of 'goodness in men' means that one compares men and makes a judgement. According to Benn, one means something like 'Jack is a good man, *as far as men go*' [my italics]. 'Good' is not only used here as a term of approval, it is also a descriptive term. How does this lead to a more objective ethics? Benn responds,

> if we can discern man's function, and discern who is living according to it, we have an objective, descriptive answer to questions about goodness in men. [32]

According to Aristotle's theory, if John performs an action that inclines him towards his function as a man then it is a right action and *vice versa*. If human goodness is construed in this way, then one negates the use of action-guiding principles and properties proposed by consequentialists and deontologists. Instead one needs to examine men in action and their goodness can be then evaluated.

**Hitting the right mark: the doctrine of the mean**

As noted in Chapter 3, virtue is not, according to Aristotle, a passion or emotion, nor is it a faculty, such as, the capacity to feel anger or fear. Rather virtue is a state of character. For Aristotle, it is possible to take more, less or an equal amount of everything, "and the equal [the mean] is an intermediate between excess and defect". [33] This is Aristotle's 'doctrine of the mean'. Take courage, for example. Here, the excess is rashness, while the deficiency is cowardice. A necessary quality of virtue on Aristotle's account is that it must aim at the intermediate. Aristotle qualifies this to mean 'moral virtue' for this "is concerned with passions and actions, and in these there is excess, defect and the intermediate". [34] Aristotle realizes, however, that it is not easy to be good; he believed "in everything it is no easy task to find the middle".[35]

**Achieving the mean**

How should one go about achieving the virtuous mean? Determining the mean is not reducible to abstract, specific moral rules or general moral principles, such as, 'maximise the good' or 'always treat others as ends'. Aristotle claimed that it is best if one tries to disregard or dismiss aiming at pleasure because this is usually a partial judgement. He held that once this is done "we are less likely to go astray.. [and].. we shall best be able to hit the mean". [36] The difficult process of determining the mean does not depend on reasoning, which might appear obscure coming from one who placed such an emphasis on this faculty in the political, intellectual and moral life. Aristotle claimed that perception, not reasoning, determined the mean. This was because the senses discover what is going on around us. This enables one to take stock of particular facts and circumstances needed to hit the mean.

**"Real" virtue**

Despite realizing the difficulty of hitting the mean, Aristotle lays down demanding criteria before people can achieve real virtue. For example, he held that giving away one's money was in terms of moral goodness insufficient. But,

> to do this to the right person, to the right extent, at the right time, with the right motive, and in the right way, *that* is not for everyone, nor is it easy; wherefore goodness is both rare and laudable and noble[37].

I am uncertain whether the above stringent criteria could be met by anyone. Further, would one wish someone to be like this? The use of 'right' also makes for an incredibly subjective checklist. For example, one might get the motive and amount 'right'. But who counts as 'the right person'? Aristotle might have thought it virtuous to give his money away to a friend, another Athenian gentleman. But would he think it virtuous to give away

one's money to someone, such as a beggar, who probably needs it more? I suggest not, because the notion of needs did not feature in his ethics.

### Virtues and desires

Aristotle believed that becoming virtuous was not a matter of learning moral rules. Instead besides cultivating certain dispositions, it concerned the education of one's desires. Aristotle viewed desires as "irrational elements in the soul". [38] While our desires might not, in themselves, realize a rational principle, when one's desires respond to a rational principle moral virtue is acquired. Reason need not ignore or override desire; indeed desire was the major motive behind all actions. On moral motivation, Aristotle held

> Actions, then, are just and temperate when they are such as the just or the temperate man would do; but it is not the man who does these that is just and temperate, but the man who also does them *as* just and temperate men do them[39].

Aristotle thus makes a distinction between "acting virtuously, and acting in conformity with virtue". [40] He claimed that the exercise of the virtues – virtuous behaviour – must represent a person's true or real character; in other words, this must be second nature. For Aristotle, persons' dispositions to make the right choices are displayed in their desires.

### Moral education

The education of character needs to be taught so that these dispositions are acquired. It is not an innate or natural process. It must begin early in a person's life, in early childhood, if she/he is to become a virtuous adult. In this sense, acquiring virtue is similar to any discipline requiring a certain skill, such as playing chess or learning to play a musical instrument, where both require plenty practice. One acts, firstly, as if one already possesses the disposition in question. This involves training oneself to do virtuous deeds.

In time, one gains the necessary dispositions to habitually achieve these things in accordance with reason and the good life.

**Moral and non-moral virtues**

There was no room in Aristotle's ethics for several common contemporary virtues, for example, kindness, compassion, and honesty. Instead the so-called cardinal virtues of justice, courage, wisdom, and temperance played a prominent role in his account of the moral life. These virtues were needed to enable human flourishing. For example, courage was needed to deal with dangerous and frightening challenges, while temperance was important because

> the ability to forswear or postpone the gratification of desire is essential to getting what we really want, and to lasting happiness.[41]

Different historical eras value different virtues. For example, Aristotle valued pride (or megalopsuchia), while later thought did not. Indeed pride was condemned by medieval Christian philosophers as one of the 'seven deadly sins'. And while Aristotle condemned boastfulness, he did not value humility. But Aristotle held that flourishing consisted in more than just the possession of moral virtues; the distinction between the moral and intellectual virtues was noted in Chapter 3.

Contemporary accounts of the virtues differ markedly from Aristotle's, hardly surprising given the 2500 years between them. For Aristotle, there was less difference between the moral virtues and other non-moral excellences. This limits one's ability to use his account to support a more contemporary - though perhaps, narrow-minded - account of the moral life. Despite this, several thinkers such as Hursthouse and Benn believe that one can derive much useful guidance on the moral life from Aristotle's ethics.

## Objections to Aristotle's ethics

### Does man have a function?

There are several established criticisms of Aristotle's ethics. First, it should not be assumed that man has a function; man might not be 'for' something. Just because man does things and these are in some way guided by a form of reasoning, does not in itself mean that this is man's function. People have various needs and interests and participate in a myriad of activities, which reflect one's values. These values, however, do not necessarily imply a function. In other words, 'can' does not mean 'should'; in Benn's words

> the mere fact that there are certain things he can do and sometimes does, is a poor ground for thinking this is what he *should* be doing. [42]

It is far from clear that man has a specific function. Therefore, it is unclear that the good life should be discerned as the fulfilment of such a function. (Compare this to the more simple function of eyes.) Even allowing that the good life is related in some way to human reason, it remains problematic to identify this "completely with the *moral* life". [43] However, Benn concedes that

> there is *some* connection between the flourishing of our most distinctive qualities, and the possession of moral virtue. [44]

Humans display many excellences besides moral ones. These include artistic and creative talents, social skills, beauty, physical strength, and mental determination. These qualities are valued in others as well as in us. Some of these are also unique to humans and as such, have a right to define the function of man.

### Is man's function unique?

Second, let us accept that man does have a function. It still does not follow that this function (whichever activity is chosen) is unique to him. Even if no other creature lives

according to reason (and this is untrue), it is implausible to claim that this is what man is *for* and that doing this will ensure his goodness.

**Why choose 'reason' as the function of man?**

Third, accept that man participates in activities unique to him, such as, sports.[45] Why is it that the life of reason is chosen ahead of these other unique human activities? In reply, one might claim that *all* of these activities are rational, that is, involve some form of reasoning. One cannot, for example, participate in sport without reasoning. This appears true. But if so, one is left with a rather empty meaning of 'reasoning', because the range of activities is all-inclusive and too broad to be insightful. Instead, one could limit the sorts of activities that one believes reflect man's rational function, such as, philosophical enquiry. But besides these rational activities, many other activities, for example playing football, presumably thought 'non-rational' or 'less rational' than those identified will remain. Since it is claimed that other creatures cannot engage in philosophical enquiry or football, why is it that one of these other activities is not held to be the chief function?

**Elitism and injustice**

A fourth criticism charges that Aristotle is elitist when he claims that the life of contemplation is the *best* sort of life for a human to lead. It is possible to lead a good life by interacting with others, by helping and caring about others, and by displaying different forms and degrees of reasoning, such as practical reasoning. Social elitism is at the core of Aristotle's ethics. Furthermore, slavery and sexism also pervade his ethics. These were norms of society, women in particular were treat unjustly by the standards of modernity; even Hursthouse, a loyal neo-Aristotelian calls these views "deplorable".[46] Only males of a high social standing, in effect Athenian gentlemen, could achieve full virtue. Contemporary virtue ethicists, for example, Hursthouse[47] and McIntyre[48] are referred to as 'neo-

Aristotelians' because they have rejected these outdated and unjust views and adapted their own versions accordingly. Benn claims that these criticisms should not detract from discussion of the remainder of Aristotle's ethics. He thinks it consistent to deny Aristotle's outdated and unjust ideas on slavery, women, and social hierarchy and still accept other plausible strands in his virtue ethics.

**Why lead the moral life?**

A fifth and perhaps more notable objection to Aristotelian ethics questions the connection between the moral life and the sort of life that might benefit an individual. This is not as close and substantial as Aristotle supposed. One is thus led to ask, "does it pay to lead the moral life?" [49] It is possible for one to fare well without being virtuous. For instance, Benn mentions the wealthy aesthete

> who lacks a social conscience, and surrounds himself with fine things and refined human company. [50]

It might be that the morally virtuous life is not the life that one wishes to lead. The virtuous life might be seen by some as too restrictive, lacking joy, and perhaps failing to benefit the person. So while one can say that possessing the virtues will help one's life to go well, this may be insufficient to convince one to fully cultivate and exercise the virtues. Morality, according to maximizing consequentialism, dictates that to prevent harm coming to others and ideally to promote their wellbeing, one ought to, on occasions, make major sacrifices to the quality of one's own life. In other words, one has quite strict obligations that urge one to have concern for others, even strangers. This is a tenet of obligation-based ethics and yet it is often overlooked; many people appear not to realize this commitment to total strangers. But some people might not accept this claim if scrutinized or at least they might question its pragmatism. Some Christian ascetics might want to claim that by making such

sacrifices, one leads the good life. But Benn thinks this position is exaggerated, believing instead that it is more plausible to say

> that a certain sacrifice of genuine well-being, of the good life for us, is necessary if we are to act well. [51]

**Responses to criticisms**

I shall make two points here.

First, it is possible for contemporary Aristotelians to accept the claim that denies creatures have a purpose, and yet still accept other claims made by Aristotle. For example, eyes have evolved over many millions of years; they exist and they enable their bearers to see. However, as Benn claims, they did not develop literally in order to see. A purpose does not necessarily lie behind the process of evolution by natural selection. However, eyes do *enable* their bearers to see. In contrast, eyes that do not enable vision are damaged or defective. Supporters of Aristotle's functionalism may ask, 'what do eyes do best? The answer presumably is 'seeing'. Then advocates of Aristotle might ask, 'is there something that humans do best?' For some, the response is 'reasoning'. In other words, for these thinkers people will flourish – fare well and lead good lives – if they reason well.

My second point concerns the second criticism made earlier: that the function of man must be unique to him. This might be wrong because the meaning of 'a rational principle' could be understood too narrowly. There are many forms of reasoning. Words like 'rational' and 'thinking' cover a multitude of these forms, which include practical reasoning, theoretical contemplation (the best life of all, according to Aristotle), perception, and experiencing emotions. It is hard to sharply define and delineate these sorts of reasoning. All involve, to some degree, an element of understanding. Further, it is unhelpful to make crude generalizations. For example, in saying something like 'emotions do not involve reasoning'

one errs, since there is a rational element to experiencing emotions. Indeed everything one does could be said to involve some form and degree of reasoning. It is alleged then that although other creatures feel and perceive, the way in which humans do so *is* unique. I concur with Benn in claiming that all aspects of one's life is affected by one's ability to reason, the latter understood broadly.

**Contemporary virtue ethics and moral character**

I shall now describe virtue ethics' account of persons' moral character, including its response to the impartialism advocated by utilitarianism. In relation to the second tenet, I look at Hursthouse's account of action-guidance, which she frames in terms of 'v-rules'. I then make a brief point about virtue ethics in relation to the moral education of people. The first and third points are two of virtue ethics' advantages over obligation-based moral theories. Hursthouse's claims are in response to the major objection levelled at virtue ethics, namely, that it fails to provide adequate action guidance. Following this section, I discuss some objections to virtue ethics and consider the plausibility of strong virtue ethics.

Obligation-based moral theories focus on the consequences of acts and the nature and content of moral obligations, rules, and principles. These theories largely neglect questions about people's characters and *their* lives. But morality concerns people's acts, thoughts, and feelings. Nothing occurs without a person's direct or indirect involvement. To rectify this inadequacy of obligation-based moral theories, one of the main concerns of virtue ethics is to provide a richer more textured account of moral character.

Virtue ethics gives special consideration to people's character traits, both the virtues and vices (discussed in Chapter 3). Virtue ethicists are primarily concerned with the kind of

person one is or wants to be. Requirements of a virtue ethics approach to morality include self-reflection, for example, on what kind of person one is and thinking specifically about the sort of life one wishes to lead. It is important to think about the value of friendships and relationships with others, as one of the aims of this approach is to live well within families and communities. Important questions include: 'how can I be a morally good (excellent) person? How ought I to act in particular situations and circumstances? What does acting in a certain way, say, kindly or cruelly say about me as a person? And, how and why ought I to respond to this person's needs?

In an attempt to derive some action guidance regarding the general question, 'what sort of person should I be?', one can ask another more specific question, 'what would a virtuous - for example, honest - person do in these circumstances?' Virtuous people will be repelled at the thought of vicious acts and take great pleasure in carrying out virtuous deeds. This can be sharply contrasted to Kant's ideas on moral worth; for him pleasure was unimportant when carrying out acts. [52] Back to Stocker's example for a moment (Chapter 3), while one might have some admiration for those who act just from a sense of duty, "we tend to think better of agents who like to do what they ought, because their good deeds express their real character". [53]

The role of motives is also crucially important in virtue ethics. One criticism of obligation-based moral theories is that they provide a hard and inflexible duty-based account of moral motivation, which does not accurately reflect the lives of humans (see the discussion based on Stocker's example, Chapter 3). Slote is one virtue ethicist who believes that virtues provide one with the reasons and motives for acts, thoughts, and feelings. In contemporary moral philosophy, Slote was, I believe, the first person to propose a strong version of virtue ethics in the form of a full text treatment.[54] Slote

believes that the virtues are admirable character traits and this forms one's reason for cultivating and exercising them. His version is unusual in that it is not grounded in Aristotle. Instead Slote's theory is derived from the moral sentimentalism of Hume and Martineau. In Slote's theory, there is one foundational virtue, namely, caring. 'Caring' is admirable and this does not depend upon, for example, the consequences of caring. For Slote, virtues *are* motives. For example, kindness is a morally admirable trait, a virtue; it also serves as the motive for action. The rightness of an act on Slote's view derives from the nature of the motive behind it. If a person does a deed from the motive of kindness, then it is a kind deed; as such it is a morally good and right deed.[55]

The two central questions in normative ethics - what should I do? and how should I be? - are not necessarily incompatible, despite the objection from obligation-based ethicists that action guidance is ignored in virtue ethics. However, it is true to say that different versions of virtue ethics attach various degrees of priority upon the status and importance of right action and prescribing action-guidance versus the notion of moral character. One could generalize and claim that obligation-based moral theories are act-centred and virtue ethics is agent-centred, because the latter makes moral character so important. But it would be unfair to claim that virtue ethics is agent-centred *rather* than act-centred. According to Hursthouse, virtue ethics is often characterized as a moral theory that concerns 'Being' and ignores 'Doing'. There is a grain of truth in this claim, which Hursthouse singles out as one of the slogans used to inaccurately describe virtue ethics. Some obligation-based ethicists do interpret virtue ethics in this simplistic way, but this is a misconception.

**Virtue ethics: the focus on the moral character of persons**

Obligation-based moral theories are charged with ignoring the assessment of moral character. But, according to many thinkers including Benn, this is a necessary component

of an adequate moral theory. Sometimes one comes into contact with people who have committed evil and deplorable deeds. For many people, actions and beliefs are either right or wrong. Some actions and beliefs are more absolute than others; that is, actions and beliefs are either absolutely right or absolutely wrong. For example, 'value human life' and 'do not murder' are for many, absolutely right beliefs, while 'harm children' is for many an absolutely wrong belief. Rather than just looking at these from an act perspective, virtue ethics is able to provide an insight into persons who commit such acts or hold such beliefs, because of its emphasis and reflection upon moral character, motives and, emotions, So instead of asking, "how is the world improved or made worse by such and such an action?" the virtue ethicist is concerned about "what the doing of this action would reveal about the one who does it?"[56] For example, would an honest or compassionate person do such a thing? Or are these the acts or thoughts of a dishonest or cruel agent? According to Benn, this way of reasoning leads us to

> a set of moral concerns that is more plausible than anything that can be delivered by purely action-based accounts.[57]

Benn provides an example that encourages one to focus on the person's thoughts. The thought in question is: having sexual fantasies about someone one knows is unavailable. This type of feeling might not result in any sort of wrongdoing. But Benn asks us to consider the following scenario: Butch fantasises about Liz, who is engaged. This does not necessarily mean that Butch will go on and attempt to seduce Liz. Indeed, some people might think that these kinds of private thoughts are pretty harmless as long as no one is harmed. However, Benn believes that this is not so simple. He holds that the aforementioned example concerns "the relationship between fantasy and genuine desire", [58] a topic that involves complex questions. For Benn, the insight into one's real character and desires highlighted by these sorts of thoughts cause him concern. In this example, Benn believes that Butch's fantasies surely reflect or express a small part of his real

desires and character. He thinks that envy, at least on some occasions, makes these spiteful deeds wrong. He writes

> an envious person might do spiteful things, but perhaps more often he will simply have envious thoughts, nursing his unhappiness that someone else has something he has not (and perhaps does not even want).[59]

People's characters are formed from one's particular set of virtues and vices. These form and shape one's motives, be they good (for example, benevolence) or bad (for example, envy). Benn thinks that motives give actions their moral complexion. This helps to dispel the common assumption

> that the only thing to worry about, with respect to certain private imaginings, is that they might be acted out. There is as much truth in the reverse; if they are acted out, much of what is objectionable about the actions is the motive and state of character from which they spring.[60]

**Virtue ethics and impartialism**

It was noted in Chapter 4 that obligation-based moral theories, including various forms of consequentialism, produce conflicts with some deep moral intuitions, such as, the wrongness of murder, slavery, and torture. Consequentialism, particularly utilitarianism, advocates impartialism; and yet some moral intuitions support partialism towards one's loved ones. The virtue ethicist, however, does not face the stringent problem of impartialism. Instead virtue ethics can accommodate the notion of partialism quite easily. Rather than asking what the abstract notion of impartiality and partiality mean, virtue ethics seeks to identify, explicate, and understand the virtues involved in forming and sustaining close relationships with others. Virtue ethics also aims to understand how one virtue, say, honesty relates to another, say, compassion. For example, compassion is an example of an other-regarding virtue (to be examined in Chapter 6), while loyalty is an example of a partial virtue exercised most often between friends and loved ones.

**Hursthouse on action guidance and the v-rules**

I noted the contribution made by Hursthouse in Chapter 4 where she discussed the neglected topic in the applied ethics literature of moral dilemmas being resolvable *only* with remainder. In *On Virtue Ethics*, Hursthouse also aims to respond to the common charge that virtue ethics cannot provide a person with adequate action-guidance.

Obligation-based ethicists charge that the virtuous agent will have no idea what to do in particular dilemmas, because they argue that virtue ethics fails to come up with any rules for conduct. Hursthouse believes that this is wrong. In her view, people have access to a whole range of virtues and, as I noted in Chapter 3, within the structure of these virtues (and vices) there is considerable moral guidance. For example, the virtues include compassion, honesty, and patience. The virtuous person would therefore characteristically be compassionate (to be discussed in Chapter 7), true to her word, and patient in the circumstances. Virtuous persons would not be non-compassionate or cruel, lie, or impatient. Hursthouse believes that despite one's own initial uncertainty, it is possible to have a very good idea of what the virtuous person would do. For example, Hursthouse asks,

> Would she lie in her teeth to acquire an unmerited advantage? No, for that would be both dishonest and unjust... Might she keep a death-bed promise even though living people would benefit from its being broken? Yes, for she is true to her word. And so on.[61]

Furthermore, Hursthouse believes that virtue ethics "comes up with a large number of rules".[62] It clearly gives one prescriptions for action, for example, 'do what is *honest*', 'do what is *just*' and 'do what is *compassionate*'. But virtue ethics also tells one what not to do, for example, "each vice [is] a prohibition – do not do what is dishonest, uncharitable,

mean". Hursthouse calls these the v-rules. I believe that this refers to 'virtuous' or 'vicious' rules, but this is not made clear.

In developing this thesis about the v-rules, Hursthouse demonstrates that virtue ethics *does* present an account of right action that includes rules, so denying the common criticism that it fails to. This criticism is grounded in the view that virtue ethics is about 'Being' rather than 'Doing', one of the slogans used to characterize virtue ethics. It is more accurate to claim something like 'virtue ethics focuses on Being, that is, moral character but does not do so at the expense of Doing, that is, action guidance'. Thus, virtue ethics provides rules for guidance. It is now possible to rebut the claim that for virtue ethics to work adequately, it needs to be supplemented with other obligation-based, for example, deontological, rules.

Given that virtue ethics does provide rules for action, are there any reasons left for thinking that it cannot tell people what to do? Perhaps the v-rules of virtue ethics are the wrong sort of rule? Rules like 'do what is honest' and 'do not do what is unkind' are like the rule 'Do what the virtuous person would do'. Hursthouse believes that the v-rules provide a different sort of action guidance than that supplied by the rules of deontology and the one rule of act-utilitarianism. More specifically, Hursthouse believes that the v-rules "are couched in terms, or concepts, that are certainly 'evaluative' in *some* sense, or senses, of that difficult word".[63]

It appears that deontologists are discontent with the rule, 'Do not kill' as they have refined it to include more sophisticated and evaluative terms, such as, 'Do not murder', 'Do not kill the innocent' and further 'Do not kill unjustly' (although as Hursthouse notes, the latter is a specific form of v-rule). Deontologists might argue that the v-rules are inferior to their own

rules when it comes to the moral education and guidance of children. In the case of children, "the simple rules we learnt at our mother's knee are indispensable".[64] The v-rules are 'thick' concepts in the sense that they are complex and sophisticated notions to pick up on. This is so for adults, but at least they can think harder about what constitutes harming someone or promoting someone's well-being. For children (depending upon age and degree of physical, mental and moral maturity), this process will be more difficult. In effect, some v-rules, including 'act charitably' and 'don't act unjustly might well be regarded as inappropriate for use with children; as Hursthouse notes "[these thick concepts are] Far too thick for a child to grasp".[65]

Hursthouse believes that the above objection - the v-rules are inadequate in providing guidance for children - is slightly different from the general one claiming that the v-rules do not provide action guidance. It is more specific and concerns

> a condition of adequacy that any normative ethics must meet, namely that such an ethics must not only come up with action guidance for a clever rational adult, but also generate some account of moral education, of how one generation teaches the next what they should do".[66]

According to Hursthouse, there are two reasons why this criticism is false. First, she holds that the claim that toddlers are taught only deontological rules is wrong. She thinks that sentences like 'Be *kind* to your brother, he's only little' and 'Don't be so *mean*, so *greedy*' are taught to children on a regular basis. However, she admits that while 'fair' and 'unfair' are taught, 'just' and 'unjust' are not for some reason. Second, Hursthouse believes that it is unnecessary for a virtue ethicist to deny such significant deontological rules as 'Do not lie' and 'keep promises'. While Hursthouse thinks it is wrong to define a virtuous agent as one who acts in accordance with deontological rules, it is perhaps an understandable

mistake to make, because of the obvious connection between the rule about not lying and the need to cultivate and exercise the virtue of honesty.

It should be clear by now that distinctions between deontological moral rules and the virtues concern motives, ends and value. Implicated here is the acknowledgement that, on the one hand, deontologists think it sufficient to teach a rule prohibiting lying, whereas on the other hand, virtue ethicists "want to emphasize the fact that, if children are to be taught to be honest, they must be taught to love and prize the truth".[67] But, according to Hursthouse, this end will not be realized via the deontological method. However, the important point is that virtue ethicists do not have to deny the usefulness of teaching children these sorts of moral rules in order to reach this end.

In summary, Hursthouse argues convincingly that virtue ethics comes up with rules for action – the v-rules. These include 'be honest' and 'do as the compassionate person would'. Moreover, virtue ethicists can also accept and accommodate the deontologist's familiar rules; certainly these rules, for example, 'do not lie' need not be rejected. The distinction between the two is concerned with their different moral foundations. For example, deontology states that lying is wrong because it violates the rule 'do not lie' therefore lying is morally prohibited. On the virtue ethics view, however, people should not lie because it would be dishonest and dishonesty is a vice.

**Virtue ethics and moral education**

Obligation-based moral theories ask, 'Is this action morally right or wrong?' In response, one typically thinks of reasons for and against doing the act. One often believes that the act with the best (most convincing) reasons should be carried out. If an obligation-based ethics is adopted, these reasons will be related to (a) maximizing utility or at least

producing good rather than bad consequences and (b) abiding by moral rules or principles. There is, however, a third source of knowledge that people can utilize when they want to know what to do. This is to seek the moral guidance of someone else, someone whom one believes is morally wiser than oneself, someone whom one admires. Indeed, the main 'method' of teaching the virtues is by instruction from others, observing other people whom are virtuous and admired and aiming to be like these people. Virtue ethics recognizes that these points are important and crucial in people's moral lives. However, obligation-based ethics appears to ignore this option. Indeed, asking others for their view is almost regarded as morally deficient. I suggest that many people seek guidance from 'wiser' people, including close friends, relatives, and colleagues. This fact is particularly important for virtue ethicists who believe that it should be accepted and endorsed for what it is, namely, a claim about something that does happen. People are a valuable resource of knowledge, ideas, and views that is sometimes needed when one really does not know what to do. Of course, this is rejected by obligation-based ethics because these theories hold that all dilemmas can be resolved as long as the person acts in accordance with its obligations, rules, and principles. But this fails to represent the moral life in realistic terms, richly textured and full of moral confusion. Virtue ethics, by acknowledging and encouraging people to seek moral guidance from others, helps people to lead morally good lives.

## Objections to virtue ethics

### What is virtue ethics?

A common criticism is that virtue ethicists are unable to come up with a simple short answer to the question, what is virtue ethics? However, no one appears bothered that this is also the case with deontology and utilitarianism. Nevertheless, this objection is thrown

at virtue ethicists as if it is a flaw in the theory itself, which is somehow meant to make virtue ethics less plausible.

Hursthouse believes that it is hard to describe virtue ethics in broad terms, "to get all virtue ethicists in", and at the same time, describe it "sufficiently tight to keep all deontologists and utilitarians out".[68] She thinks that this challenge is excessive. It is, I think, unfair, because if virtue ethicists could do this, then they would be unique among ethicists. The majority of individuals interested in moral philosophy simply do not know much about virtue ethics. This provides one reason why the non-proponents of virtue ethics want it explained in a few sentences or less. This is in contrast to the familiarity evident towards deontology and utilitarianism. These obligation-based theories are taught and studied in depth during undergraduate philosophy courses. And, in nursing education, there is evidence to suggest that consequentialism and deontology dominate the teaching of ethics.[69] I believe that Hursthouse would agree with my claim that virtue ethics is not taught as widely as the traditional obligation-based moral theories. Perhaps as more thinkers become accustomed to and more knowledgeable about virtue ethics, this situation will change for the better. It seems to me sensible to think that as more and more undergraduates learn about the virtues and virtue ethics, there will be less reason to be ignorant of this approach to morality.

**Strong virtue ethics – a viable view?**

Obligation-based ethicists believe that strong virtue ethics is implausible. Philosophers who accept the importance of virtues in morality include Rachels[70]. However, he also believes that strong virtue ethics is not a viable view. Rachels accepts that theories that emphasise right action usually neglect the importance of moral character in the moral lives

of agents. Virtue ethics, irrespective of its form, focuses upon moral character. But as Rachels reminds us,

> Moral problems are frequently about what we should *do*. It is not obvious how, according to Virtue ethics, we should go about deciding what to do.[71]

Rachels thinks this strong approach is unnecessary. He believes that one could retain the notions of 'morally right' and 'right action', but interpret these from within the virtue ethics framework. It appears, however, that Rachels has not conceived the action guidance derivable from the virtues and vices in the way that Hursthouse has done. I believe that her v-rules thesis provides a plausible and satisfactory response to the common charge that virtue ethics cannot tell people what to do. Many people know other people whom they admire and regard as virtuous. One needs to think of these sorts of people and ask, for example, 'aunt Daisy is really kind, I wonder what she would do in this situation?' Instead of thinking in broad terms, that is, encompassing all the virtues together, it is morally preferable if one takes one virtue at a time and thinks about what each separately entails. For instance, how should I act, think, and feel if I wish to be honest?

**Moral rules and deontic language versus aretaic terms**

In everyday life, there are numerous common moral rules[72] and principles, some stricter and weightier than others. For example, 'do not harm the innocent', 'tell the truth', and 'don't break promises'. These principles are considered indispensable by many deontologists. It is claimed that the content of these principles cannot be completely understood simply by reference to a specific virtue. In Benn's words,

> the concept of the virtues makes little sense apart from the idea that a virtuous individual is disposed to do the right things – and we seem to need some other account that can tell us what the right things are.[73]

Such an objection reflects the view that virtue-talk cannot replace action-talk. For many, the concepts of 'right' and 'wrong' action are so important in morality that one should not, as Anscombe[74] suggests, jettison them. Contrast this to a virtuous person: a virtuous person is disposed to think virtuously, that is, in terms of those virtues she cultivates. Further, she is disposed to do virtuous deeds, that is, act from the virtue of, for example, honesty. Strong virtue ethicists do not talk in terms of 'right action' or 'morally right action'. Instead they use the specific language of the virtues. I suggest that instead of merely referring to someone as 'virtuous', one should be more accurate and use the relevant virtue, for example, 'John is a *just* man' or 'Mary is a *patient* lady'. In this way, one can get a much better, more detailed picture of the kind of people John and Mary are. Furthermore, instead of using deontic language such as 'right' and 'wrong', virtue ethicists refer to one's acts by using aretaic terms such as 'John (and Mary) act well' or conversely 'he acts badly' about someone who has cultivated the vice of dishonesty.

**Benn on virtue ethics' exclusivity**

Benn is interested in virtue ethics' exclusivity. He asks, "With what, exactly, is virtue ethics being contrasted?"[75] Does it provide substance and content which other moral theories, such as, utilitarianism and deontology, do not? This question asks one to consider how strong (action guiding) the version of virtue ethics is under examination. Questions implicated here focus on the role of deontic notions. For example, are obligations and moral rules necessary to tell people what to do when faced with moral problems and dilemmas? Or can the virtues, operating within a virtue ethics framework, do all the work of ethics? Can virtue ethics provide adequate action-guidance? In short, can it do all that is required in morality? I suggest that because virtue ethics makes virtuous (good) moral character more important than the aim of 'making moral decisions' or the notion of 'right action', it does have something substantial and fruitful to say.

However, the above claim fails to convince Benn. He asks, suppose some actions are good and praiseworthy, while others are bad and blameworthy. Suppose further that the virtuous person (one who has cultivated the virtues) will do the good deeds and ignore the bad. The important question remains,

> Why shouldn't the good and the bad themselves be understood in terms of an action-based (non-virtue based) theory such as utilitarianism?[76]

Take utilitarianism as an example. Suppose the good deeds were those that maximised well-being and minimised pain and suffering, while the bad deeds decreased well-being and perhaps increased pain and suffering. It would be plausible for the utilitarian to say that the virtuous agent has a steady disposition "to promote the greatest happiness of the greatest number?" For utiltiarians, benevolence comes close to such a disposition. This point helps to explain why some critics, not only obligation-based ethicists, but also weak virtue ethicists, argue that virtue ethics fails to contribute anything new to moral theory. Furthermore, some critics claim that virtue ethics cannot adequately replace obligation-based moral theories, such as, consequentialism and deontology, because right and wrong conduct cannot be replaced with discussion of virtuous or vicious character. These critics fail to notice the action guidance derivable from virtue and vice terms (discussed in Chapter 3). In sum, virtue ethics is charged with failing to provide something that might make the theory attractive and convincing to non-virtue ethicists.

**The problem of completeness**

Related to the plausibility of strong virtue ethics, Rachels[77] identifies a problem concerning the sufficiency of virtue ethics. He asks, 'Is the virtue theorists' explanation of what we ought to do sufficient?' He believes that this explanation is incomplete. Take honesty as an example. The strong virtue ethicist tells us to be honest because it is a moral excellence that will help both the possessor and the benefactor to fare well in life (note: I

am talking about faring well and leading good lives in a moral sense). Conversely, being dishonest or deceitful are vices, which interfere with how humans are able to get on in life. As noted, those who cultivate the virtues are worthy of admiration and praise. Those who cultivate the vices are worthy of nothing less than moral repugnance. Probably the largest group of people are those who fail to realize the importance of the virtues; these traits are therefore not cultivated. However, neither do these people cultivate the vices. The moral assessment of these people is more difficult; one needs to know what kind of people, on the whole, they are.

**What do the virtues entail?**

Another related problem is the difficulty in knowing what a specific virtue entails. For instance, what precisely does it mean to be honest? I examined this type of question in Chapter 3, but since it is a criticism levelled at virtue ethics, I shall look at it again. The supposed difficulty in answering this question is one reason why Rachels thinks deontological rules are important in morality. According to him, the response to 'why shouldn't I lie?' needs to be more than 'because it goes against the character trait of honesty'. Why is it better to have the trait of honesty rather than its opposite? Convincing reasons are needed to show why it is morally preferable to be honest rather than dishonest (to be kind rather than unkind and so on). In response to this, Rachels writes

> Possible answers might be that a policy of truth-telling is on the whole to one's own advantage; or that it promotes the general welfare; or that it is needed by people who must live together relying on one another.[78]

However there is a problem with Rachels' comments above. The first response is akin to ethical egoism, the second utilitarianism, while the third is reminiscent of contractarianism.[79] For Rachels, strong virtue ethics is flawed because its justification for action guidance is inadequate. But it is notable that Rachels fails to mention 'we need the

virtues to fare well and help others' lives to go well too'. This is not the same as ethical egoism, utilitarianism, or contractarianism. It is a crude form of neo-Aristotelianism.

**Virtue ethics and the charge of moral relativism**

From within a virtue ethics framework, reasons for action will all be related or connected to the virtues and vices. Particular virtues and vices are deemed important in one's life and this depends, in part, upon one's needs and interests. This claim is, however, open to the charge of moral relativism. Critics might argue that no two persons have identical lives; they would suggest that in many cases people's needs and interests diverge. Each person chooses to cultivate only those virtues that will help one's life to fare well. But this means that different persons will cultivate different virtues. Two points spring to mind. First, there is no guarantee that persons will all cultivate the same virtue. Indeed depending on the number of people in question, completely different virtues might be seen as important and cultivated. For example, out of 100 people, 25 cultivate honesty, 25 cultivate patience, another 25 cultivate compassion and the remaining 25 cultivate courage. The second point springs from the first. Each person in this small community believes that the virtue that they cultivate is important to human flourishing; this is, after all, why they chose to cultivate it in the first place. It is alleged that moral relativism reigns because no absolute moral truths are generated by this approach; each person believes that 'their' virtue is the most important one to cultivate. However, while this claim is true as it stands, it fails to accurately represent the precise role of the virtues in morality. The virtues are positive character traits, moral excellences that it is good for people to inculcate, because they help one's life to go well and they tend to benefit others. The virtues are admirable traits to possess. People can realize why it is important to cultivate the virtues (and conversely why the vices should not be cultivated). One can see that in the above example, the cultivation of the 4 virtues – honesty, patience, compassion and courage – would help

their possessor and the other 75 in the community to fare well. But might the 25 people who are honest cause tensions for the remaining 75? Or might those who act courageously cause problems for the others? There is clearly something in this. As it stands, this conception of the virtues might lack sufficient theoretical resources to satisfactorily ground the virtues. This point is picked up again in Chapters 7, 8 and 9.

**The problem of incompleteness - revisited**

The strong virtue ethics approach faces another more general difficulty, related to the problem of incompleteness. Reasons to do with the virtues and vices help one to know whether to favour or object to an action. Rachels holds that strong virtue ethics must agree with the following claim,

> that for any good reason that may be given in favor of doing an action, there is a corresponding virtue that consists in the disposition to accept and act on that reason.[80]

Rachels thinks this is untrue. For example, suppose one has to decide how to distribute scarce medical resources. One might decide that it is best to do that which will maximise the benefit for the greatest number of people. Rachels asks, is there a virtue that matches this disposition? Probably not, if there is believes it should be called 'acting like a utilitarian'.

However, this example is too crude to be revealing. First, according to obligation-based ethics, the allocation of scarce medical resources will be carried out from the principle of distributive justice. From a virtue ethics perspective, the legislator will be just, he will act justly. He will be fair when allocating the resources. While this will be far from straightforward, acting justly should help to eliminate unjust and partial actions. Considerable action guidance can be derived from the virtue and vice terms of 'just' 'fair'

and 'unfair'. Clearly the virtues of benevolence, honesty, and integrity are important in making these types of decisions too. Rachels' example concerning the allocation of resources is perhaps too simplistic to be really helpful. Many sources of data will be first identified, including epidemiological data on the incidence of AIDS and data on the incidence of other diseases, for example, coronary heart disease. The allowable expenditure will be identified and a just percentage of the expenditure would be allocated to help those with AIDS and a just percentage allocated to help those with coronary heart disease and so on. Of course it is not as simple as Rachels or I make out. Many other criteria will be taken into account. However, acting justly and avoiding acting dishonestly, for example, together with considerable self-reflection, will help to rule out injustice.

**Virtue ethics: conflicts between virtues**

It was noted in Chapter 3 that one common objection to the virtues approach to morality was conflicts between virtues and how this approach can respond to this criticism. Rachels[81] identifies the 'conflict of the virtues' as a serious problem for virtue ethics. How is one meant to resolve situations where two or more virtues have been identified as important? Can the virtues be ranked? For instance, is honesty, in a given situation, more important than justice? Rachels says,

> Suppose you must choose between A and B, when it would be dishonest but kind to do A, and honest but unkind to do B.[82]

There are reasons for and against both telling the truth (and acting unkindly) and withholding information (but acting kindly). Since both kindness and honesty are virtues, it is unclear what one should do. But at the end of the day one must do something. The pronouncement 'act virtuously' clearly fails to help. This is where the idea of ranking the virtues might come in. But can this be done? Rachels fails to provide responses to this question.

**Conflicts between virtues: a response**

It is not true to say that because both honesty and kindness are virtues, a person will therefore have no idea what to do. People need to think deeply about the meaning of each virtue. One needs to think hard about what honest and kind persons are like, for example, what characteristically would honest and kind persons do? What behaviours does one expect from honest and kind persons? And what acts would honest and kind persons carry out? One should take into account particular circumstances and details in situations. These details will help to shed some light on which virtue is thought more important in a given situation.

An example might help. Sally has bought a new dress for a party later that evening. She asks Tim, her husband, what he thinks of it. Tim hates the dress, but says that it's lovely. He believes that being honest would be unkind to his wife. He therefore decides to spare her feelings and is dishonest instead, believing that this is a kind thing to do.

Accounts of honesty, as a virtue can be very demanding of the person. For example, Hursthouse provides an account of honesty in which she states that the honest person would never lie (tell an untruth), would avoid situations where lying was a possibility, would seek out situations where the truth could be told and would not wish to make friends with people considered dishonest. This interpretation of what it means to be an honest person will not be easy for many people to comply with, but such compliance is necessary in order to be called an honest person. Of course, one needs to think about the meaning of kindness too.

On the above account, Tim was deceiving Sally by intentionally telling her an untruth; in this sense he was not being honest to her. If he had told the truth, this would have been

an act of honesty. Further, he believed the truth would upset Sally, but he failed to give her an opportunity to react to the truth. Sally might have been prepared for the truth. If Tim had not liked the dress, then she might have decided to try on another. The dress may have been for a really special occasion where Sally wanted to look her best. She now believes that the dress looks good on her, partly because of Tim's dishonesty (I say 'partly' because Sally thinks it looks good too and might have bought it irrespective of Tim's views). Of course, according to some of Sally's friends, the dress does look good; perhaps Tim's taste in fashion is conservative. At the party, Sally overhears several nasty remarks about her 'dreadful' dress. She returns home early in tears. Because Tim is upset at seeing his wife in such a distressed state, he admits that he does not really like the dress. Sally feels annoyed and upset at Tim's dishonesty, even though she understands his motive. Tim regrets his actions and feels upset that he was not honest with his wife.

Another point that I think needs making is that both kindness and honesty are moral virtues. As such, these traits are examples of moral excellences, morally good traits of character that should be praised and admired. Acting from the virtue of kindness and acting from the virtue of honesty are examples of acting *well*. Tim exercised judgement and decided that he should act kindly, but dishonestly. Acting dishonestly is a vice and as such it is an example of acting badly. But I need to stress something here and that is the use of judgement. This is not to be taken lightly. Obligation-based moral theories, for example, the many moral rules and obligations of deontology and the one rule of act-consequentialism, state that there is no need for persons to use judgment in making moral decisions. One need only abide by the rules and the morally right course of action will be revealed. Virtue ethics makes exercising judgement fundamentally important to morality and to the aim of persons faring well. Tim took into account knowledge of his wife, what sort of person Sally is, which traits she admires in others, previous experiences, and

perhaps discussions that the couple had had in the past about similar situations. Based on all of these things (and more), Tim made a judgment. The motive and reason for this decision was kindness. Therefore one can say that his motive was morally good.

Also included in making a moral judgment is a complex phenomenon that I shall call 'moral wisdom'. Some thinkers, for example Hursthouse, believe that moral wisdom encompasses several deep complicated notions including moral perception, sensitivity, and imagination. Each of these I take to be necessary to the virtue ethics approach to morality. Whether consciously or not, these notions are important in order to make good moral judgments. It seems to me that Tim sensed that the situation was morally troubling. He used imagination to put himself in Sally's position. By looking at Sally, asking her questions, and listening to her responses Tim was able to perceive *some* of the morally important features of this situation. Examples of these are: consequences and outcomes, rights, motives, intentions, principles, and naturally virtues and vices. I will not go further and say that Tim could perceive *all* the morally relevant features. This is because I believe that moral perception is fraught with difficulty and I doubt whether anyone would be able to assimilate every detail, especially when the situation is incredibly multi layered, as morally tense situations tend to be. I shall examine the exercise of judgment and moral wisdom in relation to nurses' moral decision making in Chapter 7.

**Conflicts between moral obligations and rules**

Obligation-based ethicists are not immune from the conflict problem as noted in Chapter 3. Often a ranking of obligations will need to occur, which is far from satisfactory. Deontology could be charged with failing to resolve conflicts between moral obligations, rules, and principles. Things are better, in this sense, for act-utiltiarians since they have only one rule, 'maximise utility'. But many deontological rules exist. These can take one of several

forms. For example, the rules taught as children by one's parents such as 'don't lie', 'tell the truth' and 'be kind to your elders', Ross'[83] *prima facie* obligations and those proposed in medical ethics by Gert, Culver and Clouser.[84]

**Can one display a virtue in performing a bad or evil deed?**

Both Aristotle and Plato were troubled by this question. Foot and Benn examine this question in the philosophical literature. As examples, Benn gives the courage of a terrorist in planting bombs that might kill or injure innocent people and the kindness demonstrated by the 'Robin Hood' thief who steals from the rich and gives to the poor. One might ask whether the terrorist is courageous? Does he not display courage in planting bombs knowing that he could be killed or seriously injured if one exploded? Is the thief really kind or benevolent? He does appear to show some sympathy for the plight of the poor. Benn thinks that one's character is composed of both virtuous and vicious traits. But this is not the problem. His interest instead is in "whether a particular benevolent act can also be unjust, or a courageous act also cruel?"[85] Benn says,

> if we also allow that the more heedless of human suffering the terrorist is, the more courage he shows, we are implying that if he becomes more compassionate he also becomes less courageous.[86]

This opens the way to call any decrease in his courage, a deficiency. Likewise, accept that it is better to be 'perfectly benevolent' than just 'moderately' so. Further, accept that one who steals in order to help the poor displays a greater degree of benevolence than someone who refrains from stealing. A troubling implication arises because it appears that one ought to admire those who steal or kill.

One response comes from Hursthouse. She believes that a virtue such as courage in a desperado would enable them to carry out "far more wicked things than they would be

able to do if they were timid".[87] She claims that one arrives at a bizarre thought: that the virtues, which help a person to be morally good, to fare well in life, might end up in fact making a person do morally bad deeds. However, Hursthouse thinks that the desperado is daring rather than courageous. I concur with Hursthouse. In carrying out bad deeds, for example stealing, a person acts from the vices of dishonesty and injustice. The motive of the Robin Hood thief is clearly not one of the virtues; for in stealing he is not acting well and those whom he steals from will not fare well neither. I would suggest that this thief was acting like a utilitarian, because he was redistributing wealth to maximize the good.

Furthermore, the degree of benevolence one develops is not directly proportional to the amount of happiness one creates. For instance, one could be a really kind altruistic person, but fail to create substantial happiness for others; indeed 'happiness' is such an arbitrary subjective term that it becomes almost meaningless. One could be a cruel person and yet make others happy by harming their enemies. Assuming, as Benn does, that it is generally better to create more, rather than less, happiness, this does not licence others to steal or cheat. From a deontological perspective, it is morally wrong to steal because it breaks the moral rule 'one must not steal'. But, from the virtue ethics perspective, stealing is an example of acting badly (not well) because it is unjust. Thieves can live good lives, but not *morally* good lives. Others, those who have had their possessions stolen, for example, clearly fail to fare well.

Are the ends of human activity good or evil? Can someone, for instance, a Nazi soldier show courage when he is fighting for an evil cause? Does courage operate in this case as a virtue? Geach responds to this in no uncertain terms,

> Courage in an unworthy cause is no virtue; still less is courage in an evil cause. Indeed, I prefer not to call this nonvirtuous facing of danger 'courage'.[88]

This makes sense, since one does not wish to praise the Nazi soldier for what he does. However, he risks his life and acts in the face of danger. There is undoubtedly something about his actions that suggests it would be wrong not to refer to him as courageous. Rachels attempts to overcome this problem by saying,

> perhaps we should just say that he displays two qualities of character, one that is admirable (steadfastness in facing danger) and one that is not (a willingness to defend a particular regime). He is courageous all right, and courage is an admirable thing; but because his courage is displayed in an evil cause, his behaviour is *on the whole* wicked.[89]

However, this assumes that the soldier knew at the time that his cause was evil. But in truth how much freedom did a typical Nazi soldier have to refuse to fight? It was expected and obligatory for him to defend his country. Most probably, he would have been shot if he had refused to fight, so it might be said that he had no real choice. Irrespective of this, the above quote makes an arbitrary decision about what counts as 'courageous' behaviour. This appears to turn on the perceived goodness or badness of the activity in question. There is a sense in which courage *for any soldier* is clearly a virtue, needed in order to survive, protect comrades, and fare well. Furthermore, Rachels' response is unconvincing because in my view the notion of 'on the whole behaviour' and the exercise of specific virtues, tends to make an unhappy combination.

Foot provides a more convincing response to the above problem. She thinks it is wrong (or at least something about this is wrong) when people who have demonstrated apparent virtue, but for a bad or evil end, are praised; an example being the 'courageous' terrorist considered earlier. It remains difficult, however, to say categorically that the terrorist was not in some way courageous – remember he could be killed or seriously injured in the course of planting the bombs. It does appear that the courage shown when trying to achieve good or noble ends is identical to the courage shown, like the terrorist, when

trying to achieve bad or evil ends. The fact that one person decides to achieve bad or evil ends might itself be a sign of a flawed character, a deficiency in virtue. But the deficient virtue is clearly not courage. If one denies that the terrorist shows courage, then one is defining courage arbitrarily to suit one's values. So if one approves of the ends, one might use the word 'courage', whereas when one disapproves of the ends in question another more derogatory term might be used. This usage is termed 'persuasive definition'. A good example, according to Benn, is the difference shown in calling a terrorist either a 'freedom fighter' or simply a 'terrorist'. Even though the nature of what they do is the same, those who approve of the terrorist's ends will call him a freedom fighter, while those who disapprove will call him a terrorist. Foot claims that when courage and benevolence are both displayed in the pursuit of bad or evil ends, "*they do not operate as virtues* in these cases". [90]

The above point requires further explanation. The foundation for this thought is the idea that "things do not always operate according to their natures".[91] Courage, by its nature, is a virtue. In the example of the terrorist however, it does not operate according to its nature. Other examples given by Benn are prudence and industriousness[92]. Both these operate by their nature as virtues. However prudence does not operate as a virtue "in people who are so obsessed with danger that they never take even rational risks"[93], while industriousness does not function as a virtue "in people who neglect their families to advance their careers".[94] Despite the earlier claim that one needs the virtues, for example, honesty, courage, and compassion to fare well and lead morally good lives, it seems that there will be times when these traits do not function as virtues, because they do not operate according to their natures.

### Virtue ethics: supplementary or strong?

Rachels concludes that a supplementary form of virtue ethics should be adopted because he finds a strong version unconvincing[95]. However, as noted he has not been able to respond to Hursthouse's v-rules thesis. He is uncertain whether a combined theory could do justice to both the notions of 'right action' and 'virtuous character'. Will one notion be sacrificed to some degree by over emphasising the other? He thinks this is highly possible. Rachels suggests that the principle value, according to such an overall theory, might be human welfare. It follows then that a major objective will be for all humans to be able to lead satisfying and happy lives. Furthermore, he thinks one needs to consider,

> What sorts of actions and social policies would contribute to this goal *and* the question of which qualities of character are needed to create and sustain individual lives.[96]

According to this combined theory, the nature of virtue "could profitably be conducted from within the perspective that such a larger view would provide" [97]. In Rachels' view, it would be acceptable for each part of the theory – 'right action' and 'virtuous character' – to be adapted and modified a bit here and there; he believes moral truth will be the benefactor. It is doubtful, however, whether a hybrid version, like the one proposed by Rachels, could work, because the starting points for deontic (duty-based) and aretaic (virtue and vice-based) theories are fundamentally different. Modifying or adjusting one notion, whether 'right action' or 'virtuous character' would mark the end of a coherent moral theory (this is a major reason why there are few hybrid theories). [98]

## Conclusions

In this chapter I have examined the origins and development of virtue ethics. Supplementary versions of virtue ethics were identified and discussed. Merits of virtue ethics include its rich portrayal of persons' moral character. Strong versions of virtue ethics

have been developed including Aristotle's. One of the common charges against virtue ethics is that it fails to come up with rules and thus cannot provide adequate action guidance. However, in Chapter 3 I noted how people who think deeply and ask questions about the virtues can derive a lot of action guidance, especially from the vice terms. Furthermore, in this Chapter, Hursthouse has responded to the common charge that virtue ethics cannot provide adequate action guidance for persons by developing her v-rules thesis. I believe that these two claims – first, one's ability to gain action-guidance from the virtues and vices and second, the action-guidance derivable from the v-rules - means that a strong virtue ethics is a plausible option.

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[8] Rachels, *The Elements of Moral Philosophy*, pp. 189-193.

[9] Pellegrino and Thomasma's version of virtue ethics applied to medicine is best explored and viewed in the light of two previous texts that together develop a substantial philosophy of medicine. See: E., D. Pellegrino & D., C. Thomasma, *A Philosophical Basis of Medical Practice* (New York: Oxford University Press, 1981) and Pellegrino & Thomasma, *For the Patient's Good* (New York: Oxford University Press, 1988).

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[23] Benn, *Ethics,* pp.161-162.

[24] Ibid.

[25] For example, D., B. Rasmussen, "Human Flourishing and the Appeal to Human Nature" in *Human Flourishing* eds. E., F. Paul, F., D. Miller Jr., & J. Paul (New York: Cambridge University Press, 1999), pp. 1-43.

[26] Aristotle, *Nicomachean Ethics,* Bk.1, 7, p.14.

[27] Aristotle, *Nicomachean Ethics,* Bk. 1, 7, p.13.

[28] When Aristotle uses 'best' to describe a life, I think he refers to the sort of life that displays many moral and intellectual excellences, that is, many moral and non-moral virtues. Since for him, virtue is determined by a rational principle, which men with practical wisdom (one of the intellectual virtues) can discern, it makes sense that a life of theoretical contemplation, that is, the life of a philosopher should serve for him as the best life to lead. However, while it is commonly stated that achieving one's potential is a good and of value irrespective of the goals or standards attained, I believe that Aristotle on this conception would not offer praise to someone who, for example, achieved their highest mark of 42% in a maths paper, this for Aristotle, is not excellence of reasoning.

[29] Skinner (the behaviourist) used exactly the same kind of definition of 'goodness'' in his reinforcement theory"; see B., F. Skinner, *Science and Human Behaviour* (New York: Macmillan, 1953).

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[36] Aristotle, *The Nicomachean Ethics*, trans. D. Ross, revised J. L. Ackrill & J. O. Urmson (Oxford: Oxford University Press, 1980), Bk. II, 6, p.46.

[37] Ibid.

[38] Benn, *Ethics*, p.180.

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[40] Benn, *Ethics*, p.167.

[41] Ibid.

[42] Benn, *Ethics*, p.163.

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[44] Ibid.

[45] This is surely disputable, depending upon one's conception of sport, since many mammals, such as the big cats, spend much of their day playing with each other.

[46] Hursthouse, *On Virtue Ethics*, 1999.

[47] See for example, Hursthouse, *On Virtue Ethics*, 1999.

[48] See, for example, his treatment of neo-Aristotelian virtue ethics in, A. McIntyre, *After Virtue – a study in moral theory*, 2nd ed. (London: Duckworth, 1985).

[49] Benn, *Ethics*, p.167.

[50] Ibid.

[51] Benn, *Ethics*, p.183.

[52] However, one should not think that Kant ignored the role of the virtues in morality. He wrote at length about virtue, believing that agents have a strict, perfect duty to cultivate the virtues in themselves; however the reason or motive for so doing was not to help agents to fare well in life, but rather to abide by the categorical imperative. Recently, some Kantian moral philosophers and virtue ethicists have refocused on Kant's thoughts on the virtues, and much scholarly activity is now directed in this area.

[53] Benn, *Ethics*, p.173.

[54] Slote, *From Morality to Virtue*, 1992.

[55] I refer the reader to: M. Slote, *Morals with Motives* (Oxford: Oxford University Press, 2001) his latest full text treatment on the subject; and E. Garrard, "Slote on Virtue" *Analysis*, 2000, **60** (3), pp. 280-284.

[56] Benn, *Ethics*, p.170.

[57] Ibid.

[58] Ibid.

[59] Benn, *Ethics*, pp.173-174.

[60] Benn, *Ethics*, p.174.

[61] Hursthouse, *On Virtue Ethics*, p. 36.

[62] Ibid.

[63] Hursthouse, *On Virtue Ethics*, p. 37.

[64] Hursthouse, *On Virtue Ethics*, p. 38.

[65] Ibid.

[66] Ibid.

[67] Hursthouse, *On Virtue Ethics*, p. 39.

[68] Hursthouse, *On Virtue Ethics*, p.3.

[69] S. Parsons, P., J. Barker, & A., E. Armstrong, "The teaching of health care ethics to students of nursing in the UK: a pilot study", *Nursing Ethics*, 2001, **8** (1), pp. 45-56.

[70] Rachels, *The Elements of Moral Philosophy*, 1999.

[71] Rachels, *The Elements of Moral Philosophy*, p.190.

[72] For example, W., D. Ross, *The Right and the Good* (Oxford: Clarendon Press, 1930).

[73] Benn, *Ethics*, p.170.

[74] Anscombe, "Modern Moral Philosophy" eds. R. Crisp & Slote in *Virtue Ethics*.

[75] Benn, *Ethics*, p.169.

[76] Ibid.

[77] Rachels, *The Elements of Moral Philosophy*, pp.189-191.

[78] Rachels, *The Elements of Moral Philosophy*, p.191.

[79] M. Lessnoff, *Social Contract* (Oxford: Polity Press, 1988); D. Gauthier, *Morals by Agreement* (Oxford: Oxford University Press, 1986).

[80] Rachels, *The Elements of Moral Philosophy*, p.192.

[81] Rachels, *The Elements of Moral Philosophy*, pp.189-191.

[82] Rachels, *The Elements of Moral Philosophy*, p.191.

[83] See, for example, Ross, *The Right and the Good*, 1930.

[84] B. Gert, C., M. Culver & K., D. Clouser, *Bioethics: A Return to Fundamentals* (New York: Oxford University Press, 1997).

[85] Benn, *Ethics*, p. 170.

[86] Benn, *Ethics*, p.175.

[87] Hursthouse, *On Virtue Ethics*, p. 13.

[88] P. Geach, *The Virtues* (Cambridge: Cambridge University Press, 1977), pp. 29-30.

[89] Rachels, *The Elements of Moral Philosophy*, p.180.

[90] Benn, *Ethics*, p.177.

[91] Ibid.

[92] While this might sound promising, does it apply to all the virtues? Does it, for instance, apply to justice? It is difficult to imagine justice *not* operating as a virtue.

[93] Benn, *Ethics*, p. 177.

[94] Benn, *Ethics*, p. 177.

[95] According to Benn, virtue ethics cannot be free-standing. Instead it requires help from act-theories. He thinks this partly because impartial moral concerns are more morally important, and will override, the importance for one of the good life. So, if accepted, this means that (Aristotelian) virtue ethics cannot adequately capture the objectives of these concerns.

[96] Rachels, *The Elements of Moral Philosophy*, p.193.

[97] Ibid.

[98] Hare's indirect two level account of utilitarianism (examined in Chapter 3) counts as a hybrid moral theory. But despite the fact that the second level contains deontological rules, Hare is certainly not viewed as a deontologist.

# CHAPTER 6 – A CRITICAL ACCOUNT OF OBLIGATION-BASED MORAL THEORIES IN NURSING PRACTICE

## Introduction

Having established the value of the virtues and the plausibility of a strong version of virtue ethics, I return to the topic of obligation-based moral theories, but I now contextualize these within nursing practice.

This Chapter provides a critical account of obligation-based moral theories in the context of contemporary nursing practice. First, I consider reasons why obligation-based theories are popular in nursing. I examine the deontic approach in the literature and briefly describe 3 moral decision making tools. Then I describe and examine the 'Four Principles' approach to bioethics. I close by examining several flaws of obligation-based moral theories as utilized in nursing practice. I conclude that these theories are inadequate for use as a foundational nursing ethics.

### Why are obligation-based moral theories popular in nursing?

Despite the widespread view that patient-centred and holistic nursing care ought to be key objectives of contemporary nursing practice, a biomedical focus on practice remains predominant.[1] The epistemological paradigm that grounds medical practice is empiricism. Consequently, there is a focus on the disease process, making diagnoses, identifying clinical needs, planning and delivering effective treatments, with an increasing emphasis nowadays on evidence-based practice [2] and clinical outcomes.

I discussed the popularity and dominance of the traditional obligation-based moral theories in general ethics in Chapter 4. In medical practice, the paradigm of empiricism and the primary focus on outcomes sheds some light as to why obligation-based moral theories have become so popular, if not dominant, in health care ethics. It makes sense to suppose that popular theories in general ethics will then be utilized in professional ethics.

I suggest that the moral theories adopted by doctors have influenced and motivated the moral theories chosen and utilized by nurses. Doctors are charged with the medical responsibility of patient care. Although the role of a nurse (Chapter 2) is different to the role of a physician, there is reason to believe that medics greatly influence nursing practice and the work that nurses do. For example, Walsh and Ford[3] state that the medical profession continues to dictate the breadth and depth of information given to patients and relatives. I doubt that this is the only example of practice in which medics exert influence, power and control over nurses. It is true to say that obligation-based ethics provides a framework of moral principles that can be used for reflection and application in particular situations. Such frameworks can, especially for novice nurses, serve as a useful moral checklist to facilitate moral reasoning including the aims of minimizing harms and making the right moral decisions. Both in terms of clinical nursing ethics[4] and the teaching of ethics[5] to qualified and student nurses, obligation-based moral theories are popular.

Hospitals are large, complex institutions. To enable such institutions to operate efficiently, the norm is to develop rules that persons must abide by. Rules can be utilitarian in content and scope. The aim is to maximize the effectiveness of the institution. Such familiarity of and reliance upon rules might help to explain why medics

and nurses favour obligation-based ethics over other alternative moral theories. Adopting a philosophical perspective that says 'I must follow the rules laid out by the hospital' can make it easier, at least for some people, to abide by moral rules because the type of thinking utilized is in essence the same. Walsh and Ford[6] claim that nursing remains task orientated and that it is organized as a series of rituals and traditions. For example, carrying out clinical observations such as blood pressure and temperature every 4 hours and delivering so-called 'pressure area' care every 2 hours. It is plausible to suggest that nurses still perceive their work as a series of tasks (or jobs) that they need to 'get done' rather than spending quality time with patients.[7] The aims and objectives of obligation-based moral theories – for example, an extreme focus on actions and their consequences, resolving moral problems and making 'right' moral decisions - can be seen to cohere tightly with the emphasis in clinical practice on 'getting things done', making correct diagnoses, identifying outcomes of treatment and resolving clinical problems. In summary, there are reasons why nurses (and doctors) have adopted and continue to utilize obligation-based moral theories in clinical practice.

**Examples of the deontic approach in the nursing literature**

I shall now examine in brief some examples from the recent nursing literature in which the authors adopt an obligation-based approach. These articles invoke moral obligations, rules and principles to resolve moral dilemmas in nursing. The authors assume, or write as if they assume, that all dilemmas are resolvable. The authors appear to claim that there is one right or wrong answer to the dilemma. Sometimes the claim is that of the two harms present, one is less harmful or a bit more beneficial to the patient than the other. The possibility that a dilemma could be irresolvable is not mentioned; at least the authors do not make this possibility explicit to the reader.

This section aims to present an accurate representation of the obligation-based approach to morality frequently debated in the nursing literature, taught in ethics modules for nurses, and, as noted above, utilized in moral decision making in nursing practice. Fourteen articles were identified using the Cumulative Index of Nursing and Allied Health Literature (CIHAHL) in 1999. The keywords were 'ethics', 'mental health nursing' and 'psychiatric nursing'. I use five of these articles to illustrate the obligation-based approach to ethics. However, four points need noting. First, the remaining 9 articles are synonymous in their approach.[8] Second, the authors fail to regard the virtues as important to the ends of being a morally good nurse.[9] Third, subsequent literature searches conducted in 2002 and 2003 yielded similar findings. And fourth, obligation-based moral theories are as popular and widespread in adult nursing literature as in mental health nursing literature; several examples of the former are cited throughout this thesis.

1. Kashka and Keyser[10], by means of a principle-based approach and case study, examine ethical concerns in relation to informed consent and ECT. An ethical quandary is defined in terms of conflicts or tensions between two ethical principles, namely, beneficence and autonomy. They conclude that an increased emphasis upon ethical principles is needed from nurses. The authors believe

   > nurses must be grounded in the ethical concepts discussed, [and that] knowledge of the specific situation is also necessary to the decision-making process.[11]

2. In an introductory chapter in a text on ethics in mental health practice, Kentsmith, Miya and Salladay[12] claim that knowledge of philosophy, ethics and 'ethical thinking' will help nurses make 'better', 'clearer' and more justifiable day to day decisions. 'Ethics' is defined as

   > a branch of philosophy that examines right and wrong, what

> should or should not be done, and the moral justifications for action.[13]

The authors subdivide 'ethics' into axiology - "the study of values" - and morality, which is further broken down into teleological, deontological, absolutist and relativistic ethical theories. No mention is made of the virtues or character traits needed to be a morally good nurse, a notable omission given the remark about axiology and discussion of the nurse-patient relationship early in the chapter. Kentsmith *et al* claim that nursing is regulated by ethical codes of conduct. They state that ten ethical principles are implicated in ethical practice, including "a responsibility to the client", "an obligation to act ethically" and "a respect for the law".[14]

3. Hopton[15] considers ethical arguments for and against controlling and restraining (C&R) individuals in severe mental distress. He sketches utilitarian and deontological perspectives in relation to the ethical justification of C&R. With the first, the conclusion is

> efficient restraint [the force used must be less injurious than the initial aggressive act] will minimise the harm done to both the restrained person and anyone else.[16]

Hopton holds that deontological arguments are of limited use insofar as there is minimal "agreement concerning how far a mentally distressed person is accountable for his/her actions".[17] However, I suggest that the notion of responsibility and accountability for one's actions, while noted as an important issue in nursing, equally applies from a consequentialist perspective. Hopton continues to claim that an obligation exists, irrespective of ethical perspective, for nurses to protect innocent others from the violent acts of the mentally distressed. However, Hopton provides no qualification in relation to his discussion of utilitarianism. I do not know whether he means act, rule, or indirect utilitarianism or indeed whether he thinks this distinction is unimportant. This lack of

detail in moral theories and moral arguments is not uncommon in the nursing literature. In my view, crude forms of the theory in question are sometimes presented. Or as Hursthouse[18] claims mere 'slogans' are used to describe these theories. Therefore, in part as a result of the literature being rather unsophisticated, nurses may fail to develop a substantial understanding of moral theories, including their problems and limitations. Also lacking in this article is any conception of 'harm' so central to Hopton's discussion. Do we wish to say that emotional suffering is a component of 'harm' in general? Or instead, is one solely referring to physical injury? I think Hopton would concur with the first question above, but perhaps he should have made this explicit. Similar points can be made regarding his discussion of 'deontological arguments'. Surprisingly, there is no explicit mention of one's 'right to psychiatric treatment' and more importantly 'rights to refuse treatment'. And although Hopton makes reference to one's need to protect others, no explicit mention is made to duties or obligations to protect innocent others.

4. Chodoff[19] distinguishes between, and explicates, the medical model and civil liberties approach to the ethical issue of involuntary hospitalization of the mentally ill. He claims that these two different approaches are grounded by, respectively, consequentialist and deontological ethics. Issues such as medical necessity versus the notion of 'dangerousness', the role given to rights versus obligations and the justification of medical paternalism depend upon value judgements arising from these contrasting moral perspectives. Because of these issues and since no one has yet developed a sound 'method' for deriving 'ought' propositions from 'is', there is no certainty about the good and right thing to do in this matter. These claims – which I concur with – represent some of the serious flaws in obligation-based moral theories (Chapter 4 and also later in this Chapter). These criticisms provide good reasons why alternative moral theories, such as virtue ethics, should be examined.

First, Chodoff discusses utilitarian versus deontological approaches to ethics. He defines utilitarians as those who

> believe that the morality of an act is determined by the extent to which that act serves the good of individuals or the society.[20]

Whereas, deontologists,

> maintain that whether an act has good consequences should not be the only factor determining its rightness or wrongness.[21]

Chodoff claims that the sole criterion for right action, besides the 'good', may lie in other intuited principles, such as, fairness, liberty and justice. The two moral approaches of utilitarianism and deontology are then applied to the ethics of involuntary hospitalization. Chodoff writes,

> the doctors who embrace the medical model are following a utilitarian ideal. For them the removal or diminishing of the barriers that mental illness imposes on the healthy functioning of their patients is the right thing to do. It justifies temporary deprivation of physical liberty.[22]

However, the civil libertarians see things differently; as Chodoff claims "they are more concerned with the coercive aspects and with the loss of liberty". For these thinkers, liberty as a value "trumps" [23] other values. Chodoff believes that psychiatrists should neither take too lightly the decision to involuntarily commit, nor place extreme emphasis upon the notion of physical liberty. With the latter, there will be some people with mental illness who require treatment, but presumably would not receive this.

Chodoff provides an adequate definition of utilitarianism, although it is uncertain whether this is meant to encapsulate the doctrines of classical, act or rule utilitarianism. No mention is given to direct or indirect forms of utilitarianism, neither is there further discussion of Chodoff's interpretation of the 'good'. It is also a bit amiss that he fails to discuss the notion of a person's 'interests', as this is fundamental to utilitarianism. For

example, he does not mention that strict classical utilitarians hold that everyone's interests ought to be treat equally and impartially, that is, no special relationships, such as, doctor and patient are acknowledged.

Chodoff briefly mentions 'obligations' in the article. However, he fails to discuss this or the 'duty of care' further. Despite these minor criticisms, his article can be praised because it does not make recourse to professional and legal duties. This has the advantage of facilitating a *moral* discussion. There are occasions when so-called 'moral' or 'ethical' debates end up as discussions about the law, legal rights and legal obligations. This is true across all nursing specialties, but it is particularly the case in mental health nursing where the two disciplines of ethics and law tend to merge together and the boundaries become blurred.

5. Brown focuses upon and discusses "a number of key ethical issues with regard to drug treatment".[24] First, he considers the risks and benefits of drug treatment; this includes a brief section on the boundaries of mental illness. Second, the doctor-patient relationship and the notion of informed consent in particular comes under scrutiny. Next, the patient's moral and legal rights with regard to drug treatment are discussed. Finally, Brown briefly examines the issues of drug costs and social justice. Brown does not propose a specific moral argument. Instead, he reviews ideas mainly concerning patient's rights, although he fails to philosophize on these.

**Examples of moral decision making tools or models**

One of the features of the obligation-based approach in general and nursing ethics is the aim to resolve moral dilemmas. Moral dilemmas and moral problems are complex and multifaceted and by definition extremely difficult to resolve satisfactorily.[25] Irrespective of

one's clinical and moral experience and knowledge base, dilemmas can be fraught with conflicts between obligations, values, desires and wishes. In an attempt to facilitate the resolution of moral dilemmas and problems, there are several examples of decision-making tools and models in the literature. I briefly describe three of these below. This helps to illustrate some of the assumptions made by the obligation-based approach to morality.

Kentsmith *et al* claim that using "systematic problem solving tools" can enhance "the analysis of ethical dilemmas".[26] They give one such example which consists of the following 6 'stages': "determine the facts"; "analyse the ethical aspects"; "outline the options"; "make a decision"; "take action"; and "evaluate the decision". For novice nurses and/or nurses who struggle with understanding the discipline of ethics, such 'tools' and 'stages' can clarify some of the moral issues and facilitate moral decision-making. However, these are conceptual tools that require application. It needs to be emphasized that these stages require nurses to ask relevant questions and think carefully about a wide range of nursing actions.

Ericksen's theoretical framework model for dealing with the steps of ethical reasoning consists of 5 areas of knowledge: knowledge of oneself and one's values; b) knowledge of the situation; c) knowledge of the profession's values and standards; d) knowledge of the law; and e) knowledge of philosophy. It is claimed that by adopting this framework, it is possible "to make a decision that will be in the best interests of both nurse and client".[27] The utility of this framework will be determined by the nurse's breadth and depth of knowledge across these 5 distinct areas. Plus, there is the difficult philosophical debate regarding the meaning and nature of 'best interests' to consider.[28]

Dissatisfied with current measuring instruments[29], McAlpine, Kristjanson and Poroch[30] developed the Ethical Reasoning Tool (ERT) to measure the ethical reasoning ability of nurses. This tool measures nurses' thinking about practice dilemmas that are unprompted, instead of asking nurses to rank existing lists of issues. The authors claim that the ERT could be used to evaluate the teaching of ethics modules and to detect deficient areas of students' ethical reasoning. Possessing an empirical understanding of moral reasoning can be seen in a positive light, especially if it led to beneficial changes in the teaching of ethics to nurses. However, it is not clear what the ERT actually measures; it seems to me that it might measure a person's understanding of the question or one's ability to be articulate.

The above 3 decision-making tools fail to examine a nurse's moral character, instead it is true to say that the focus is placed on the actions, but not the person who carries out the action.

**The four principles approach to biomedical ethics**

Beauchamp and Childress[31] first proposed this approach to biomedical ethics (henceforth called 'principlism') in 1979. It consists of four moral principles: (a) beneficence, (b) non-maleficence, (c) justice, and (d) respect for autonomy. Beauchamp and Childress' influential text has developed through 5 editions and is currently one of, if not the, most popular texts used in the teaching of ethics to health care professionals. In the UK, thinkers, such as, Edwards[32] and Gillon[33] have advocated principlism.

Principlism can be viewed as four second order moral obligations, derived from the first order moral theory of deontology. It is however difficult to be more specific because the

underlying philosophical foundation appears to derive from what Hursthouse calls 'simple' deontology.[34] The claim that principlism is a coherent moral theory has itself been attacked[35]; while Beauchamp appears to be a deontologist, Childress seems to be a utilitarian. However, there is no doubt that principlism represents an obligation-based moral approach to resolving moral dilemmas in contemporary health care. Because principlism is popular in the literature and in both clinical ethics and nurse education, I shall discuss each principle in more detail in the following sequence: non-maleficence, justice, autonomy, and beneficence.

**The principle of non-maleficence**

The principle of non-maleficence concerns balancing benefits against harms and generally minimizing the latter. There are many examples of this reasoning in nursing. For example, a nurse may note that a patient who is taking a particular psychotropic medication, such as lithium, is in distress because of excessive shakes. The nurse consults with the psychiatrist and the dose is lowered. This is more effective in that the patient's symptoms remain controlled, but the shakes cease.

The obligation of non-maleficence 'to do no harm' (or in contemporary health care, 'to minimise harms') appears to be morally weightier than the obligation of beneficence. Simply put, from the obligation-based perspective it is not always possible to benefit a patient, thus it is more important to ensure that no harm or minimal harm is caused.

However, the obligation-based perspective views 'benefits' in a narrow sense. As noted earlier, from the virtue-based perspective, the range of actions, thoughts and feelings that demonstrate benevolence, kindness and compassion is extremely wide. From the perspective of obligation-based ethics, the phrase 'no benefit' can mean something like

'I'm sorry, I cannot help you, there is no cure, there's nothing I can do for your cancer'. However, it is morally appropriate to consider actions such as listening to the patient's lived experience of illness and helping to alleviate physical discomfort perhaps by providing adequate analgesia or repositioning a limb as examples of actions and behaviours that in a number of ways help the patient. Nurses and health care professionals might interpret the obligation of non-maleficence in terms of *just* physical harms. Psychological or emotional harms can be overlooked. This might contribute to paternalistic actions, because the non-medical harms and interests of the patient perhaps remain unidentified.

Clouser and Gert[36] view this principle as unproblematic. They are however more specific about it, framing it in terms of the moral rules that they espouse, for example, "don't kill, don't cause pain and don't disable". [37] The principle of non-maleficence is straightforward because, according to Clouser and Gert, it does not blur the distinction between moral ideals (what Kantians call, 'imperfect' duties), which concern the prevention of harms and moral rules (what Kantians call, 'perfect' duties), which concern the avoidance of harms.

**The principle of justice**

This principle is often seen in terms of distributive justice: how scarce medical resources ought to be allocated.[38] However, retributive justice addresses such important ideas as blame and punishment and is therefore also important in nursing ethics.[39] According to the principle of justice, nurses should treat patients fairly and impartially irrespective of one's values and beliefs. Patient's individual needs should be identified and taken into account in planning and delivering nursing care. Of course, there will be times when caring for patients impartially will be difficult (Chapter 7).

Beauchamp notes that different theories of justice have been proposed. He writes,

> To cite one example, an egalitarian theory of justice implies that if there is a departure from equality in the distribution of health care benefits and burdens, such a departure must serve the common good and enhance the position of those who are least advantaged in society. [40]

Thus, the principle of justice can be understood to mean different things depending upon which theory of justice is adopted. Clouser and Gert attack this principle, as it "does not even pretend to provide a specific guide to action". [41] This criticism illustrates a general concern regarding principlism. This is that principlism does not provide a coherent philosophical foundation. Therefore, one is left without the necessary theoretical ammunition with which to make justifiable moral decisions. So, for example, under the Beauchamp and Childress account of the principle of justice, all that is offered are instructions regarding matters of distribution and recommendations towards fair allocation of resources. The problem is that one is not given a definite account of any one theory of justice or fairness. This sort of omission is typically used to describe principlism as 'empty'. [42] Moreover, according to Clouser and Gert, the principle of justice blurs the distinction between moral rules and moral ideals.

**The principle of respect for autonomy**

Beauchamp describes 'respect for autonomy' as "the obligation to respect the decision-making capacities of autonomous persons". [43] It appears to represent the core of their approach to biomedical ethics. Both this principle and the term 'autonomy' are widespread in contemporary health care. This now appears to be the predominant moral principle.[44] The western liberal tradition, which emphasizes human freedom, liberty and human rights, is one of the reasons why the principle of respect for autonomy is held to be so important.[45] Moreover, the Patient's Charter[46] and the

Human Rights Act[47] have increased patients' awareness of moral and legal rights, in particular the realization that patients have legal rights to refuse treatments.

Before I examine what it means to *respect* someone's autonomy, I need to clarify the meaning of autonomy itself.

**Autonomy[48]**

In contemporary health care ethics, the moral responsibility of nurses and other health care professionals appears to be understood,

> In terms of the rights of person-in-cares, including autonomy-based rights to truthfulness, confidentiality, privacy, disclosure and consent, as well as welfare rights rooted in claims of justice.[49]

A moral requirement of these autonomy-based rights involves allowing others to make their own health care decisions, in other words to promote personal rule. For this to be free, it needs to be

> Free from both controlling interferences by others and from personal limitations that prevent meaningful choice, such as inadequate understanding.[50]

However, it is not particularly clear what meaningful choice consists in. For example, even if, according to the above definition, it is agreed that an individual is acting or choosing autonomously, it is difficult to be accurate about which act or choice represents the autonomous nature of the individual. [51] Childress claims that health care professionals should pursue autonomy for their patients. He believes that autonomy is an end state of health, but he also stresses that one should be aware that "individuals may autonomously choose not to pursue [autonomy]".[52] For example, someone could visit his doctor's practice and ask his doctor to 'sort me out'. This person trusts his doctor

and respects his doctor's expertise, therefore he wants the doctor to 'do his job'. This patient's choice remains an autonomous one.

Besides Beauchamp and Childress, how do other health care ethicists conceive autonomy? Gillon, a respected ethicist and General Practitioner, defines autonomy as,

> The capacity to think, decide and act on the basis of such thought and decision, freely and independently, and without, as it says in the British passport, let or hindrance.[53]

In other words, at least one general component of autonomy is the notion of self-determination. Others share this view. For example, in an article about the ethics of informed consent and the use of ECT Kashka and Keyser define autonomy as "one's right to self govern, to assert individual choice".[54] This capacity - to think, decide, choose and act for oneself - is considered a good and is widely encouraged. Similarly, 'thinking for oneself' and 'getting by independently' are seen positively and people are usually praised for having these qualities. One crucial point made by Gillon is that when one performs an act or makes a choice, these should be voluntary and not hindered or prevented by unwanted interference.

Regarding mental illness, there is a view that mental illness *per se* will adversely affect one's mind to the extent that one will be unable to make one's own health care decisions. This is a gross oversimplification. Certainly some 'severe' mental illnesses such as clinical depression and schizophrenia can affect the faculties of perception and reasoning. But even with these illnesses, things are not straightforward and predictable, as one cannot generalize individual responses to and experiences of illness. Kashka and Keyser hold that psychiatric patients, unlike for instance surgical patients, are "less capable of considering complex information". They claim that symptoms of mental

disorder affect cognition, mood and judgement. Thus decision-making competence can be adversely affected and decisions might be less rational. But again it is not useful to generalize. The view that everyone with a mental illness will be less able or unable to make one's own health care decisions is a false and inaccurate belief and should be contested. The notion of decision-making competence is a graded concept that is object and subject specific. Regular evaluation is necessary, because the presence of mental illness does not necessarily mean that one will be incompetent to make health care choices.

One of the concerns with the idea of acting autonomously is that people can argue that they should be allowed to do what they want. Justification for this claim is derived in part from the principle of autonomy and more importantly, the moral requirement that one should *respect* the autonomy of others. However, a crucial question surrounds the notion of harming others. For example, is it morally justifiable to limit one's autonomous behavior if one harms or threatens to harm others?[55] There needs to be some limits applied to the range and scope of autonomy. In nursing practice and education, because the notion of autonomy and the principle of respect for autonomy are particularly important, it is valuable for nurses to have some understanding of these notions, including their meaning, application and problems. However, this does not always occur. Inadequate understanding and misguided application of this principle can often result. The application of a moral principle to a particular situation, perhaps deemed to be a moral problem or dilemma, with the aim of resolving the problem, is a feature of the principilist approach.

### Kant on autonomy

The focus and emphasis on 'respecting one's autonomy' is commonly attributed to the moral philosophy of Kant. He believed that 'Reason' and the ability to make rational choices defined a person.[56] For Kant, rational nature existed as an end in itself,

> Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means.[57]

However, Kant's conception of autonomy (he called it 'autonomy of the will') contrasts with the more liberal interpretation it holds today. Kant rejected the idea of democracy. He claimed that many people should not be allowed to vote. He also believed that some people could not be trusted to fulfill their moral duties. Kant held that people's rational choices should be respected because people have the *capacity* to choose. However, he also believed that one's *actual* choices should not necessarily be respected for what they are. Furthermore, despite being recognized as the founder of the notion of autonomy, I believe that Kant would support paternalistic interventions in at least some situations in contemporary health care.[58]

The meaning of the notion of autonomy is far from clear, both in theory and in practice. It is clearly more complex than often realized. It involves many strands of thought and issues pertaining to broad and deep areas of human life, such as, choosing and deciding. The term autonomy can be used to refer to different ideas, depending upon which issue one wishes to support or reject. Nevertheless, some consensus is reached on a 'minimum conception' of autonomy. This might include such issues as allowing the competent patient to make one's own health care decisions (even if others deem these decisions to be bad).

It is one thing to agree on certain issues pertaining to autonomy, but what might it mean to *respect* someone's autonomous decisions?

#### Respect for autonomy

Knowing what is meant by 'respect for autonomy' is different from understanding the range of issues and subjects that fall within the gamut of autonomy. Downie and Calman suggest that

> To *respect* a person as an autonomous being..... is to take into account in one's conduct that he/she has an autonomous nature, that he/she is self-determining and self-governing or that he/she has desires, feelings and reason.[59]

Precisely *how* can a nurse show respect for a patient's choice?

Does a nurse show respect if she asks a patient for his view on having a treatment such as chemotherapy or electro convulsive therapy (ECT)? This does not appear sufficiently true. Surely showing respect concerns more than *just* asking someone for their view. Is respect shown when a nurse asks a patient for his view *and* listens closely to his reply? Again, one can listen to a friend's views on, for example, the quality of situation comedies on UK TV, but if one proceeds to ridicule ones friend's views then this behavior might upset him. This sort of behavior does not demonstrate respect.

Does a nurse respect a patient's choice by telling him openly that she disagrees with his choice? This is certainly an honest thing to do. Respect could be shown if the nurse listens closely to what the patient says and makes it clear to him that she values his view. Indeed, a large part of showing respect to a patient involves the delivery of well-

developed interpersonal skills (Chapter 2). Finally, is respect shown if and only if despite disagreeing with a patient's choice, for example, 'no nurse, I don't want another ECT treatment', the nurse and multidisciplinary team *abide* by the patient's decision? One can see that showing respect (and disrespect) is a complex notion, which involves several related issues.

**The principle of beneficence**

An important reason behind the inclusion of this moral principle lies in the historical tradition of health care ethics. For centuries, the accepted goal of medicine was one of medical beneficence. It remains widely accepted that nurses, doctors and health care professionals should strive to serve this particular end of health care. According to Beauchamp,

> The principle of beneficence expresses an obligation to help others further their important and legitimate interests by preventing and removing harms; no less important is the obligation to weigh and balance possible goods against the possible harms of an act. [60]

Kashka and Keyser claim that beneficence should be outcome centred. They believe that "doing good for clients, or acting in their best interests is the primary value [in nursing]".[61] In their view, beneficence "involves the perceived duty to 'do good', to contribute to the welfare and happiness of others".[62] In relation to beneficence, Frankena states

> We ought to do the act or follow the practice or rule that will or probably will bring about the greatest possible balance of good over evil.[63]

One should note that this is a utilitarian interpretation of beneficence. Other possible conceptions include rights-based (libertarian) and of course virtue-based. The latter views benevolence (including kindness) as the corresponding virtue to the obligation of

beneficence.

Irrespective of the philosophical grounding, the moral foundation of nursing remains the obligation of beneficence. The motivation for nurses to 'do good' for their patients has several sources. These include patients and their relatives, the NMC, one's colleagues, society and one's own moral code. According to this principle, nurses are obliged to benefit patients. Examples of acting from this obligation are too numerous to list, but include: administering paracetamol to a patient to alleviate a headache; repositioning someone in bed to prevent a pressure sore; administering chemotherapy to kill cancer cells; providing ECT to treat depression; feeding a patient; and comforting a patient by listening to his narrative account of illness.

Clouser and Gert make the charge that this principle (along with justice and autonomy) makes a serious error. They claim that it blurs the distinction between moral ideals and moral rules. Furthermore, they criticise this principle because it fails "to distinguish between the preventing (or relieving) of evil and the conferring (or promoting) of goods". [64] Clouser and Gert argue that to prevent or relieve harm one may be justified in violating certain moral rules, whereas no such justification would be possible when merely conferring benefits.

Some criticisms of principlism have been noted in this section. From a virtue-based perspective, one major criticism of principlism is its neglect of the role of the virtues in the moral lives of patients and nurses. It was not until the fourth edition of *Principles of Biomedical Ethics* in 1994 that the topic of the virtues and a corresponding virtue ethic was thoughtfully, yet still only partially, debated. This position has been greatly improved by Beauchamp and Childress in the latest 2001 edition. The latest edition

contains a substantial chapter devoted to the role of the virtues in biomedicine and a rigorous account of virtue ethics as an alternative moral theory. These changes are perhaps in response to the degree of criticism that previous editions of the text received for its failure to examine the moral character of nurses and patients and the moral theory of virtue ethics.

**Disadvantages of obligation-based moral theories in nursing**

In Chapter 4, I examined the merits and disadvantages of obligation-based moral theories in general ethics. Some of these have also been repeated in this Chapter. I shall now summarize some of the main disadvantages/weaknesses of this approach to morality.

First, obligation-based moral theories focus on the nature and consequences of actions and the idea that nurses are obliged to act in accordance with certain morally weighty obligations. I would add that this focus is excessive and as a result other morally relevant features such as virtues, motives and intuitions (these are discussed in more depth in Chapter 7) are ignored and neglected. For example, the moral character of the person (both nurse and patient), how the content of the obligations should be applied and the role of emotion in the moral lives of nurses and patients are all glossed over.

Second, the aims and objectives of obligation-based theories include the resolution of moral dilemmas and problems. As highlighted in the literature (earlier in this Chapter and in Chapter 4), it appears that an assumption is made that all morally tense situations can be 'satisfactorily' resolved. But the issue of how a nurse might *feel* during and after these sorts of complex, morally emotive situations is not debated.

Third, obligation-based moral theories, in particular act-utilitarianism, but also forms of deontology, neglect the role of judgment in the moral life of nurses. This is in sharp contrast to the reality of contemporary nursing practice.[65] Also, there is no discussion or examination of the notion of moral wisdom, which again is an important consideration regarding how nurses make moral judgments. It seems that the reality of clinical nursing is not acknowledged.

Fourth, as Hare noted in Chapter 4, obligation-based theories, especially deontology, fail to provide sufficient action-guidance and direction to resolve the myriad of conflicts between duties that arise in nursing practice. Attempts at lexical ordering and assigning different moral weights to distinct obligations do not go far enough. Nurses are still left without the necessary conceptual tools whereby an attempt can be made to clarify complex, multidimensional conflicts.

Fifth, the notions and concepts used in obligation-based theories are evaluative in nature. As a result it is difficult, if not impossible, to arrive at shared meanings and common understandings. For example, the notions of 'harms', 'benefits', 'interests', and 'respect' are all far from simple to fully comprehend. Especially for novice nurses, this is not an ideal situation. Instead, it is one that leaves some nurses either (a) bewildered at the complexity of the discipline of ethics or, in my view, worse, (b) certain that by simply following a moral principle or rule, a morally correct and right action is guaranteed.

Sixth, in general obligation-based moral theories tend not to debate the moral education of nurses. In other words, exactly how and why should nurses be taught to be morally good nurses?

Finally, it seems to me that obligation-based ethics coheres tightly with the biomedical model. I have mentioned how the empirical paradigm of medicine emphasizes certain features of clinical practice, for example, clinical outcomes and results. One of the attractions therefore of obligation-based moral theories, especially consequentialism, is that they too focus to a large extent on the consequences and outcomes of actions and omissions. However, one of the most pressing aims of contemporary nursing is to move away from 'doing tasks' and 'achieving good results' and instead to promote and deliver patient-centred and holistic nursing care. If nurses only utilized obligation-based moral theories then there is a danger that the content (aims and objectives) of such theories will conflict with and oppose these objectives of contemporary nursing. Rather than the relational or narrative perspective taken by virtue ethics, I view obligation-based ethics as detached theories, because their focus is not on the person (the patient and nurse) but the act itself.

## Conclusions

Adopting an obligation-based moral approach in nursing means that nurses are in effect compelled to abide by certain moral obligations, for example, beneficence. This approach focuses on the nature and consequences of actions, especially the idea of right and wrong actions. The Right - that is, aiming to identify and carry out right actions - is seen as prior to the Good - that is, being a good, moral nurse. The emphasis is on right (correct) actions instead of good nurses, good moral character and morally good actions. Note that a morally right action/decision is not necessarily equivalent to a morally good deed (Chapter 4).

According to the deontic approach, nurses are obliged to act 'ethically' and 'do the right thing'. This means that nurses ought to act in accordance with moral obligations, rules and principles. But moral obligations, rules and principles are external to the person; therefore these morally relevant features might not seamlessly integrate with the kind of person (nurse) one is. In other words, obligations that instruct nurses to act in certain ways might not represent the actual natural character of the nurse. So, for example, a cruel nurse can still benefit a patient, perhaps by giving him paracetamol for a headache. It is quite clear that this act – giving paracetamol – has a beneficent effect. However, it is less clear what the nurse's motive is. Perhaps she would respond by saying that she acted from the duty of beneficence. But it has been noted (Chapters 3 and 5) that something of value is missing from actions that are not performed from the virtues. Moreover, if this nurse uses the obligation-based approach to guide her practice, then it is possible that she will not reflect about kind and compassionate *thoughts* and *feelings* and how these sorts of morally relevant features can have a positive impact on the lives of patients. Furthermore, from my experience of teaching ethics to both student and qualified nurses it appears that there is some blurring between moral and legal obligations, responsibilities and rights. Instead of their practice being guided by moral virtues or moral principles and/or moral, some nurses are motivated to act from a legal duty.[66]

Obligation-based ethics hold that nurses who do not abide by external obligations, rules, and principles have in some sense failed their 'professional' status as nurses and could – depending on the particulars - be held blameworthy for their actions or omissions. While this might appear to be reasonable, much will depend on the particulars of each situation. For example, it is possible for a nurse, with an unblemished career, whom colleagues admire, to end up in dispute with the NMC because she was deemed to

contravene or breach a specific professional rule. Perhaps in the circumstances the precise rule was one that the nurse felt was harsh and/or inflexible. Perhaps she acted well to help the patient. However despite acting from the virtue of, for example, honesty or kindness, this nurse ends up being suspended and investigated by the NMC. It was thought that her kindness breached a professional rule set forth by the NMC in its Code of Conduct. [67] Does one episode of 'rule-breaking' warrant the premature end of this nurse's clinically and morally excellent career?

Codes of conduct are clearly important for the protection of the public from clinically incompetent and morally corrupt or bad nurses. If nurses wish to fare well in a professional sense, then they need to abide by, or at least not contravene, the code of conduct. Serious misconduct is grounds for losing one's nursing registration. However, this does not mean that codes of conduct[68] in general and the NMC code in particular are without their problems. The NMC code is both deontological and consequentialist in content. It focuses on patients' interests, outcomes, and benefits. It fails, however, to provide conceptual adequacy. Furthermore, despite the contemporary emphasis on effective, high quality care there is a definite failure – a lost opportunity – to identify and examine the important role played by moral virtues in the work of nurses and the impact of the virtues in providing morally excellent care.

In Chapter 4, I examined several flaws of obligation-based moral theories in general ethics. In this Chapter, some of these flaws have been examined in the context of nursing practice. Four notable flaws of these theories are: their neglect of the moral character of nurses and patients; their over focus on the nature and consequences of actions; their ignorance of the crucial role played by emotion in the moral lives of

patients and nurses; and the incompatibility of obligation-based theories with the current emphasis upon, and desire to promote, patient centered and holistic nursing care.

Because of these flaws, obligation-based moral theories are incomplete and inadequate moral theories for use as a foundational ethics in nursing practice. In the next Chapter, I apply the virtue-based approach to morality and a corresponding virtue ethics to nursing practice.

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[18] R. Hursthouse, *On Virtue Ethics* (Oxford: Oxford University Press, 1999), pp. 4-5.

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[23] R. Dworkin, *Taking Rights Seriously* (London: Duckworth: 1978).

[24] P. Brown, "Ethical aspects of drug treatment" in *Psychiatric Ethics*, eds. S. Bloch & P. Chodoff (Oxford: Oxford University Press, 1991), pp. 167-184, p. 167.

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[27] S. Loubardias, "Ethics of electroconvulsive therapy consent", 1991, **16**, 2, p. 89.

[28] It is necessary to analyze the notion of 'interests', for example, what are interests? Who can possess interests? Can a foetus have interests or only competent adults? What about a person in Persistent Vegetative State (PVS)? Dworkin has made a distinction between critical and experiential interests. Good health would be an example of a critical interest, while one's enjoyment of football would be an experiential interest. Even if, however, it is accepted that interests are subjective and value-laden entities, it is

another thing entirely to evaluate what is "in the best interests of both nurse and client". Empiricism does not lend itself to evaluating one's interests.

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[30] H. McAlpine, L., Kristjanson, & D. Poroch, "Development and testing of the ethical reasoning tool (ERT): an instrument to measure the ethical reasoning of nurses", *Journal of Advanced Nursing,* 1997, **25**, pp. 1151-1161.

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[40] T., L. Beauchamp, "The 'Four Principles' Approach" in *Principles of Health Care Ethics,* ed. R. Gillon, (Chichester: John Wiley & Sons, 1994), pp.3-12, p.6.

[41] Clouser & Gert, 'Morality vs. Principlism', p.253.

[42] From Clouser & Gert, 'Morality vs. Principlism' p.253.

[43] Beauchamp, 'The 'Four-Principles' Approach', p.3.

[44] Evidence for this claim is found in (a) the breath and depth of literature on the subject, (b) the centrality of the notion of autonomy in the teaching of ethics to nurses and other health care professionals and (c) the importance of this notion and associated concepts, such as, informed consent, in research ethics.

[45] However, this situation was very different in the early 19th century. Then, non-maleficence (understood simply as 'do no harm') and beneficence (understood simply

as 'to do good') were the physician's primary duties towards his patients. According to the British physician Thomas Percival, the moral weight ascribed to patients' rights of autonomy (though limited compared with today) came beneath the two more fundamental obligations of beneficence and non-maleficence.

[46] The Department of Health, *The Patient's Charter* (London: DoH, 1992).

[47] The Department of Health, *The Mental Health Act* (London: DoH, 1983).

[48] The word 'autonomy' derives from the Greek and literally means self-rule.

[49] Beauchamp, 'The 'Four-principles' Approach', p.5.

[50] Beauchamp & Childress, *Principles of Biomedical Ethics,* p.121.

[51] This problem lies at the heart of the confusion present in attempts to resolve medico-moral problems that appear to turn on the meaning, application and importantly, limits, to autonomy.

[52] J., F. Childress, *Who Should Decide? Paternalism in Health Care* (New York: Oxford University Press, 1982), p.65.

[53] Gillon, *Philosophical Medical Ethics,* p.61.

[54] Kashka & Keyser, "Ethical issues in informed consent and ECT", p. 15.

[55] I shall not discuss this particular point further, but it is clearly important to human morality, justice and sharing good lives. See J., S. Mill, *On Liberty* (London: J., W. Parker & Sons, 1859).

[56] Kant distinguished between humans and non-human animals, the latter he argued did not posses the faculty of reasoning.

[57] I. Kant, 'Grounding for the Metaphysics of Morals' 2nd section: 429, trans. J., W. Ellington (Indianapolis: Hackett Publishing Company, 1981).

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[68] For example: M. Healy & J. Iles, "The establishment and enforcement of codes", *Journal of Business Ethics* 2002, **39** (1), pp. 117-124.

# CHAPTER 7 – VIRTUE-BASED MORAL DECISION MAKING IN NURSING PRACTICE

## Introduction

I shall first summarize several points made in Chapter 2.

First, illness causes people to feel certain emotions, for example, vulnerability, helplessness, and powerlessness. The process of hospitalization can intensify these feelings. Second, patients depend on nurses for help to meet their needs and interests. The nurse-patient relationship should be a helping and therapeutic relationship. Third, nurses work within a multidisciplinary team. Within this team approach, nurses' roles are multifaceted and complex. But the development and sustenance of a helping relationship is one role of the nurse. Nurses help to ensure patients' survive and recover from illness and fare well if possible. Or when nursing patients with terminal illness nurses help to ensure patients have good deaths.[1] Fourth, nurses can view the patient's illness in the form of a narrative; such illness forms only one aspect of a patient's life. To understand a narrative, a nurse needs to listen, ask questions and converse with the patient including the desire to listen to the patient's lived experience of illness. This approach contrasts with the medical model. Fifth, according to some patients and some patients' relatives, being a 'good' nurse and providing 'high' quality care includes such issues and themes as: nurses spending time with patients; getting to know patients; and listening to patients to find out their problems and needs. The helping nurse-patient relationship is valued as greatly as, if not more than, other clinical interventions. According to some nurses, empirical evidence suggests that being a 'good' nurse requires both practical abilities and moral qualities; the latter include demonstrating honesty, compassion and trustworthiness.

Obligation-based moral theories have been rejected as incomplete, flawed and hence inadequate for use as a nursing ethics.

In this Chapter I shall focus on one of the merits of the virtues and virtue ethics and apply it to nursing. This is the crucial role played by judgment and moral wisdom in the moral lives of persons. I shall demonstrate how nurses can use judgment, moral wisdom and the virtues to make morally good decisions. Examples utilize the virtue of compassion, but I also briefly note the value of courage and respectfulness. The exercise of the virtues and the use of judgment and moral wisdom can be referred to as the virtue-based approach to moral decision-making. I examine other merits of the virtue-based approach to nursing practice. Then, problems of the virtue-based approach are discussed, in particular the conflict of the virtues problem highlighted in Chapters 3 and 5. I end the Chapter by arguing that the virtue-based approach in nursing practice and a strong virtue ethics is a viable and plausible rival to the traditional obligation-based moral theories such as utilitarianism and deontology.

## Judgment and moral wisdom

### Judgment

In Chapter 4, Hursthouse[2] examined the 'Strong Codifiability Thesis' (SCT). There were two distinct parts to this thesis: (a) moral obligations, rules, and principles amount to a decision procedure to determine the *right action* in *any* particular case and (b) this decision procedure needs to be stated in terms so that a non-virtuous person could understand and apply this correctly. Obligation-based moral theories, for example, act-utilitarianism, state that it is adequate and sufficient to apply its single rule 'maximize best consequences'. However, as noted in Chapters 4 and 5 one of the criticisms of obligation-based theories is that their portrayal of human life, including the moral life and moral experiences, is much simpler and straightforward than it really is. If one looks again at the SCT above, the italicized words are there to

emphasise that the focus is on telling people what the 'right action' is and the belief that it is always possible to determine what the right action will be irrespective of the circumstances.

I am not going to repeat all of the objections levelled at obligation-based moral theories as discussed in Chapters 4 and 6. But if I focus for a moment on the phrase 'morally relevant features' that often appears in the literature, I believe that these features include the following concepts or qualities: (1) the consequences or outcomes of acts and omissions, (2) duty-based intentions and motives, (3) the nature, content, and application of moral obligations, rules, and principles, (4) rights-based reasons, (5) moral virtues, including virtue-based intentions and motives, (6) people's needs, interests and values (7) intuitions and (8) religious beliefs. In nursing practice, I believe that such issues as (9) past experiences and (10) clinical knowledge are also relevant.[3] One can see that obligation-based theories fail to discuss several important and necessary features of the moral life. These theories – at least in their traditional forms as discussed in Chapter 4 - tend to over focus on just (1) – (3). Or, perhaps if the theory is deontological, there might also be room to accommodate (4). Obligation-based moral theories seem to claim that other morally important features, such as the moral character of persons are unimportant in providing an adequate account of morality, moral decision-making and the moral lives of persons.

What is missing from this list? What do persons exercise to make decisions and choices? More specifically, what do nurses use? My response is simple: judgment. Note what I said above about act-utilitarianism and the application of its single rule. Take an example such as the morality of breaking a promise. It might well be that act-utilitarianism, deontology and virtue ethics agree that the right thing to do is that that minimizes suffering. But for virtue ethics the process of getting to this resolution

is not as simple as it is for the other two theories. Virtue ethics uses judgment to ask questions, for instance, was this the sort of promise that should never have been made? Should it be broken? What might some of the effects be if the promise is broken? One can see that questions can be framed in terms of the promise and the consequences of breaking it. Of course, questions should also address the people involved, for example, what does the breaking of this promise say about the character of the person who breaks it? If it was a silly extravagant promise, what does this say about the person who made it? Discussing *consequences* does not provide problems for virtue ethics. The notion of consequences, outcomes or results *is* important in morality. One cannot dispense with talk of consequences and one need not, virtue ethicists do not wish to dispense with this notion. But the acknowledgement that consequences are important in morality is very different from constructing a moral theory *based* on this notion. Particularly when such a theory excludes other equally important moral features.

I believe that part (a) of Hursthouse's SCT is a fair representation of the aim of obligation-based moral theories. Turning to deontology for a moment, common moral rules such as 'do not lie' are undoubtedly important in morality and especially in educating the young to 'do the right thing'. Virtue ethics talks about the virtue of honesty and the vice of dishonesty; its pivotal objective is to educate the young to be good persons. It is clear that the moral rule 'do not lie' and the virtue of honesty are related. Virtue ethics need not reject deontology's rules. However, Hursthouse[4] believes that instead of merely teaching children about rules and the need to abide by such rules, it is crucial that children are taught to love and prize the truth by teaching the virtue of honesty. I agree with this claim. It seems to me that there are several differences between the two approaches, which have been examined in Chapters 3 – 6. Two are worth reiterating here. First, it comes back to moral motives: should someone tell the truth in a particular case because he has been taught that he

must abide by certain rules such as 'never lie'? Or should one tell the truth because one understands that it is good to be honest, that morally speaking, honesty is a virtue and people benefit from it and that morally speaking, dishonesty is an example of acting badly? Second, it should be clear by now that morality is not *just* about actions and actors. Virtue ethics is unfairly characterized as a theory about Being rather than Doing. But more accurately, virtue ethics emphasizes the role of moral character, responsiveness towards others and questions about *being,* for example, what kind of person should I be? An account of right action is just one requirement of an adequate moral theory. Thoughts and feelings are also morally important phenomena; virtue ethics recognizes and makes room for this.

I believe that consequentialism – act and rule – are incomplete and inadequate moral theories. I have given my reasons in Chapters 4 and 6 and one or two have been briefly noted above.

I also have serious objections against deontology. However, from a virtue ethics perspective, deontology's rules tend to be reasonable, they make sense and I can see how useful they are in moral education. I am therefore reluctant to cast all of deontology's rules aside without further reflection. If people are to find deontology's moral rules helpful and acceptable, there are at least four points that I would like addressed. First, rules should be clearly articulated and framed to allow 'ordinary' people (that is, non-philosophers) to understand them. Second, such rules need to be specific enough to provide relevant action-guidance, but should also be flexible enough to apply them with success in different circumstances. Third, justification for the rules should be clearly set forth, explaining the rule's origin and why it is important. Situations involving conflicts between rules are unavoidable. Thus, fourth, explicit acknowledgement of such conflicts should be evident and a suitable 'method' of resolving such conflicts should be clearly explicated.

However, deontological theories remain incomplete and inadequate (discussed in Chapter 4). Moral rules, obligations and principles are not sufficient in morality. One major point that appears to receive minimal attention by deontologists is that moral rules are not somehow magically applied. Instead, it is persons who actually determine how the rules are applied. For example, nurses apply the rules, obligations, and principles of deontology (and the rule of act-consequentialism). Two nurses might apply a specific rule, for instance, 'do not breach confidential information' in different ways. One may reveal a piece of information that the other nurse would not. Or two nurses acting from the obligation of beneficence[5] might act in distinct ways. This is partly because the nature of obligation-based concepts is evaluative. For instance, taking 2 common moral rules as examples, what might it mean to (a) 'promote the patients' *interests*' and (b) 'do no *harm* to the patient'?

Besides the evaluative nature of moral rules, obligations and principles, one further necessary consideration regarding the different ways that a nurse can act is the moral character of the nurse applying the rule. This is why an examination of the virtues and vices and a corresponding virtue ethics is so important. The need for a nurse to exercise judgment is important because (as noted above) moral rules are evaluative and thus can be conceived and interpreted in different ways. Furthermore, the range of morally relevant features is broad. In a particular interaction with a patient, a nurse might consider some of the 10 aforementioned features. The NMC code of conduct also provides a degree of action-guidance; it is clearly deontological in content, although because it talks about 'interests' and 'outcomes' it also espouses a crude form of consequentialism. I say 'crude' because there is minimal philosophical analysis and argumentation in the code. Judgment is utilized in deliberating about all of the possible morally relevant features. For example, one needs to ask questions about their importance in a given situation, evaluate their meaning and utility and reflect about possible difficulties and limitations with each

one.

**Moral wisdom**

Virtue ethics states that persons should use the virtues and judgment to make morally good decisions. Hursthouse, for one, goes further and recognizes the notion known as 'moral wisdom'. For her, this complex phenomenon contains three components: moral perception, moral sensitivity and moral imagination. I am reluctant to claim that these components are sufficient for moral wisdom, but they are clearly involved and worthy of further examination.

**Moral perception**

Several thinkers have drawn attention to the role of emotion in moral thinking, including moral perception and sensitivity.[6] Oakley, for example, believes that emotion is a necessary feature for moral perception and that without emotion this faculty is diminished. According to Aristotle (Chapter 5), it was perception, not reason that allows persons to see and understand specific facts, circumstances, and details of situations, which enables one to exercise a virtue to the right degree.

Lutzen and Nordin[7] conducted a grounded theory study involving 14 psychiatric nurses, each with a minimum of 5 years post registration experience in mental health nursing. The broad aim of the study was to reveal additional dimensions of moral decision-making. Interviews were carried out with each nurse, one question was asked:

> Can you tell me about a situation in which you had to make a decision concerning patient care but were unsure what was right or wrong.[8]

The method of constant comparative analysis revealed the core concept: structuring moral meaning. There were 3 interrelated properties to the core concept: perceiving,

knowing, and judging. According to the authors, 'perceiving'

> in relationship to moral conflicts is the capacity in which the nurse discerns meaning in her observations in order to comprehend the reality of the situation.[9]

Perception will be understood according to Lutzen and Nordin's conception above. Simply put, it is one's capacity to see and provide meaning in observations and experiences. The range of observations and experiences that nurses can perceive is vast. I see no point in even attempting to provide a list of such observations and experiences. Some examples of these are given in this thesis. If I presented such a list, it would be a form of crude reductionism: richly textured, complex and multilayered personal experiences described in a few short sentences. One of the key points is that nursing is saturated with morally and emotionally tense situations. So much happens at an intrapersonal and interpersonal level that it is difficult for nurses to perceive well. There will be times when certain information is not perceived. Several factors can affect one's ability to perceive. One's knowledge base is clearly important including clinical knowledge of illness. If a nurse understands aspects of an illness such as arthritis, then thoughts will be triggered that will enable her to search for specific signs. Or questions will be asked that seek to identify certain possible symptoms. For instance, a patient is taking anti-inflammatory steroids. The nurse is aware that this type of medication can affect skin quality; sometimes the skin can be so fragile that haemorrhage easily occurs. Two other factors that might affect the quality of perception are time and the emotional well being of the nurse. In brief, if there is insufficient time for a nurse to deliver all interventions, then less time might be spent in direct contact with patients; a nurse might need to work at a faster pace so that she can manage to meet patients' needs. This situation can be intensified if a nurse is emotionally and physically tired.

Moral perception concerns one's ability to see, discern meaning and understand the wide range of morally relevant features that might be involved in particular interactions. Previous experiences need to be examined. This examination includes self-reflection and reflection about the patient's illness. This in part promotes one's ability to perceive and evaluate situations. From the examination of consequentialist and deontological moral theories in Chapters 4 and 6, it seems to me that neither of these theories emphasizes moral perception; indeed the phenomenon of moral wisdom tends to be ignored by obligation-based theories. Having said this, obligation-based moral theories are not precluded from examining moral wisdom including moral perception. However, obligation-based theories, particularly act-consequentialism with its one rule 'maximize best consequences' but also the moral rules espoused by deontology holds that judgment is unnecessary to evaluating right action.

Is it possible to shed more light on the meaning of 'judging'? When I judge a song, for example, I listen to it. I think about its composition, I consider how the music and lyrics work together and I think about the song's emotional effect on me. Am I moved by it? What does it make me think of? How do I feel when I listen to it? I might compare one song with another written by the same artist and I will think about similarities and differences. If a friend asks me for a judgment on a particular song, then I will give him my opinion. In this way, my judgment is a conscious decision based on a process of reasoning and reflection. When I make judgments, I am making choices. If the object of a judgment is aesthetic, for example music, then such a judgment is based on certain personal values and beliefs. For instance, while listening to a song, I tend to prefer the music to the lyrics, but another person might focus on the lyrics. This is an example of a value judgment. There is a sense in which all judgments are based on values; thus judgments, conceived as decisions and choices, are subjective and personal. In the Lutzen and Nordin[10] study noted, the

process of judging was found to involve 2 aspects: valuing and idealizing. According to the authors, these aspects "refer to the dialectical components, personal values and professional ideals, in judging alternatives".[11] This claim relates to the conflicts experienced by nurses between, on the one hand, the rules laid down by institutions such as hospitals and rules proposed in professional codes of conduct and, on the other hand, one's own value and belief systems.

Several empirical studies suggest that nurses use intuition and instincts in making moral decisions in nursing practice. For example, Lutzen and Nordin[12] found that nurses relied heavily upon intuition and 'feelings' for moral perception rather than moral theories such as principle-based ethics.[13] One conclusion drawn from this study "indicates that moral decision making within the nurse-patient relationship is not always deduced from rational thinking or principles".[14] Moreover, rather than moral principles or codes of conduct nurses focus on responses towards patients and take different contexts into account regarding the nurse-patient relationship in defining their own choices and decisions.[15] Furthermore, in terms of moral perception, nurses see, understand and communicate morally tense situations using the language of the virtues and vices, for example, 'fair', 'care', 'well', and 'honest'.[16] Experiential evidence derived from 15 years of clinical experience working in adult medical nursing environments and 18 months in nurse education leads me to concur with these empirical studies. For some nurses, formal moral theory does not appear to be useful. Indeed my personal experience is that even with substantial knowledge of moral theory and health care ethics, on reflection my moral decision-making appears to have been grounded in intuition and emotions/feelings towards the patient. According to some nurses whom I have taught, one of the difficulties in trying to understand the meaning of moral obligations such as 'respect for autonomy' and 'beneficence' and moral concepts such as 'informed consent' is their evaluative nature. For some nurses, perhaps this difficulty – comprehending the evaluative

nature of moral language - is one reason why they instead rely on personal qualities, intuition and instinct in moral decision-making.

#### Moral sensitivity

To be sensitive to a person's needs suggests that one is able to identify one's needs, perhaps more easily than another person is able to. The phrase 'morally sensitive' connotes a positive and admirable quality; one that in a nurse suggests that care will be morally good. In contrast, if I am insensitive to my friend's feelings, then I might fail to perceive his feelings and as a result, I might act as though his feelings do not matter to me. To be a morally sensitive nurse, it is insufficient to merely perceive patients' needs. One's perceptions ought to produce a morally appropriate response; perceptions also help to form one's moral motives. According to the virtue-based approach to morality, one should respond to another person's needs and interests in morally good ways. Nurses should act, think and feel from the virtues, for example, honesty, kindness, trustworthiness, respectfulness and courage. Take kindness as an example. Acting kindly towards a patient is an example of acting well. But as noted earlier the virtues are concerned with thoughts and feelings too, because these affect how one responds to someone else. Kind thoughts and feelings are morally good. Kind responses towards patients tend to have positive effects on a patient's ability to survive illness and then recover and fare well.

Sensitivity towards patients' needs and interests including reflection about morally relevant features can be seen as moral sensitivity. The opposite – lack of moral sensitivity or moral insensitivity – can manifest itself in various ways. These include: (a) the lack of insight that some nurses demonstrate towards patients, for instance, in relation to allowing a patient some privacy; (b) nurses who are unaware of a patient's embarrassment when the patient is attempting to micturate while precariously balanced on a bedpan; (c) nurses who are apparently oblivious to the need for a

patient to have time alone with his or her spouse to discuss private and intimate matters; and (d) nurses who stand behind the curtains talking quite loudly, therefore allowing other patients to hear private and confidential information. During my career as a clinical nurse, I strived hard not to make assumptions about peoples' values and beliefs. With regard to nurses, it is a false assumption that they will be morally sensitive to a patient's needs including their distress.

One of the major aims of current nurse education is to develop morally sensitive practitioners.[17] Being morally sensitive might include the notion of being empathetic[18] or having fellow feeling for another person's needs. It seems to me that one component of displaying moral sensitivity is one's ability to assimilate information – clinical and moral – and interpret it to provide help for a patient and respond in morally good ways; the latter meaning 'acting from the virtues'. The context and particulars of each situation, observation or interaction need to be taken into account and given considerable thought. The ability of nurses to think about a wide range of notions including patients' characters, needs, interests and desires is important to being sensitive. However, it is not enough to merely ask relevant questions in an attempt to gather important information (although even this is not straightforward for contemporary nurses).[19] To develop moral sensitivity, it is crucial that nurses aim to make sense of such information, including information revealed in conversations with patients.

I mentioned earlier that several authors have drawn attention to the important role played by emotion in moral thinking and the moral life generally. Occasionally 'emotion' (the plural is not used), for example, sympathy, compassion and empathy are held to be synonymous with the virtues. On my conception of a virtue (Chapter 3) compassion counts as a virtue, but I reject the claim that sympathy and empathy[20] are virtues. Oakley[21] states that emotions are felt experiences composed of desires

and cognitions, which are manifested towards others. Clearly the helping relationship between nurse and patient involves emotion. One of the aims of the virtue-based approach to morality is to promote the nurse's ability to identify the patient's needs and interests and respond to these by acting, thinking and feeling in morally virtuous ways. One could replace the language of needs and interests and instead say that nurses ought to respond to patients' emotions in morally virtuous ways. This is one reason why in Chapter 2, I examined some common emotions experienced by ill patients.

**Moral imagination**

Scott[22] has examined the idea of 'imaginative identification'. In her words,

> For example, I may become angry with my mother due to certain comments she makes and directs, unfairly in my view, at my husband (who is present during the scenario). However I suggest that the anger is a direct response to my perception of the hurt/embarrassment I might feel if I were my husband listening to the comments.[23]

The faculty of empathy appears to be related to the activity of imagination. Or at least imagination involves being empathetic. Perhaps empathy is a necessary, but not sufficient component of imagination. It seems to me that the activity of imagination requires one to put oneself in another person's position (as Scott did above). Questions might include 'how would I feel if that cruel comment was said about me?' and 'how would I feel if the nurse spoke to me in such a callous way?'

Part of thinking about the virtues and emotions involves the activity of imagination. In relation to moral imagination and the moral life, Murdoch[24] believes that one sees that which confronts one by attending properly, by looking selflessly and completely. The objects of such attention should be things of value such as virtuous people and the notion of goodness itself. Nurses can think hard about the virtues and vices and

imagine how such traits as compassion and patience can lead to morally good interpersonal responses.

**The virtue-based helping relationship**

I view the helping relationship between nurse and patient as one grounded in moral virtues (I shall refer to this as a virtue-based helping relationship). Nurses will need to inculcate several moral virtues if they wish to respond to patients in a wide range of morally good ways. Examples of virtues that are important in the development and sustenance of morally good helping relationships are compassion (including benevolence or kindness), courage, respectfulness, patience, tolerance, justice, trustworthiness, and honesty. For example, regarding the first three virtues, I suggest that the virtue of compassion is the moral foundation of the helping relationship between nurse and patient. Courage is a moral virtue that is needed by a nurse if she wishes to be an advocate for a patient. And the virtue of respectfulness is one of the virtues necessary to empower patients.

The above list is not exhaustive; different virtues will be implicated depending on the role and aims of the nurse, the patient's needs and interests and the range of morally relevant features that are considered important to the interactions. The fact that the focus might be on one individual virtue, for example, compassion, does not mean that others, for example, justice will be neglected. Indeed, the virtue-based approach to morality holds that the virtues *per se* are crucial to leading morally good lives. It is difficult to imagine a nurse developing a virtue-based helping relationship based on *just* one virtue, therefore ignoring other crucial virtues.

In the next section, I examine the virtue of compassion.

**The virtue of compassion**

What does compassion consist of? What does it mean to call someone compassionate? Suppose a nurse says of a colleague, 'she has loads of compassion'. What is it that she is describing? These sorts of questions can be applied to all moral virtues. If responses to these kinds of questions are inadequate, then critics might object to the virtue-based approach to morality because it is insufficient. It seems to me unsatisfactory and indeed futile to say something like, 'John, a staff nurse, needs to show compassion to his patients' if in reality (a) John does not know what it means to show compassion and/or (b) John's colleague, Sandra, understands compassion in a different way to him, hence John and Sandra respond to patients in distinctly different ways, meaning their actions, thoughts, and feelings differ.

Compassion is a common notion in nursing. I use 'notion' because compassion is often referred to as a dimension or faculty needed by nurses. Kinion, Jonke and Paradise simply state that nurses "must show compassion"[25]; however, this command suggests an underlying deontic reason for showing compassion. Furthermore, Kinion *et al* provide no conception of compassion; indeed the term 'compassion' is merely noted once at the end of the article. Therefore, one does not get far in understanding this complex virtue.

In what ways should one with compassion act? According to Blum, compassion "requires the disposition to perform beneficent actions".[26] The actions of a compassionate nurse will benefit the patient. Such beneficent actions can be physical/medical or non-physical such as alleviating emotional distress. It is plausible to believe, as the nurses in a recent modest Delphi[27] study did, that a component of

compassion is another virtue, namely benevolence[28] or kindness. Kind acts, thoughts and feelings are part of being a compassionate nurse.

What about motives? A compassionate nurse's motive for action is internal. The virtue of compassion forms part of one's identity. It is one character trait that shows other people the kind of nurse one is. Because of these internal dispositions and motives, being compassionate comes naturally to one; having compassionate thoughts and feelings and acting from these is a natural response for the compassionate nurse. Furthermore, if the nurse understands the virtue-based approach to morality, then she will *want* to help patients survive illness, recover and help their lives to fare well, according to the patient's needs and interests.

Pellegrino and Thomasma claim that besides a moral dimension, compassion includes an intellectual dimension,

> it consists in the disposition habitually to comprehend, assess, and weigh the uniqueness of this patient's predicament of illness.[29]

This point relates well to the discussion in Chapter 2 about patients' lived experience of illness and nurses being inclined and motivated towards listening to patients' narrative accounts of illness.

With regard to doctors, Pellegrino and Thomasma believe that objectivity is lost if practitioners become too involved or co-suffer too much with patients. An element of this is plausible; one can see problems, such as emotional burn out, if all nurses were to excessively co-suffer with patients. It is likely that some nurses would respond to this by saying something like 'I couldn't carry out my role effectively if I became too immersed in a patient's problems'. Moreover, from a virtue-based perspective, *nurses* would not fare well if they co-suffered too much. By extension, if

all nurses co-suffered to an excessive degree and were emotionally distressed as a result, then this would adversely affect the quality of the helping relationship, which could result in patients faring less well than they might otherwise.

The virtues, especially compassion, but also benevolence and honesty, developed as an important pattern of interest throughout the Delphi study[30] noted above. This 3 round questionnaire study aimed to examine how mental health nurses make moral decisions. Compassion was given 16 diverse meanings. This is unsurprising given its phenomenological complexity; certainty about issues and concepts such as compassion would trouble and concern me. This is because nurses are individual moral persons, with particular moral views and different experiences. A sense of ambiguity, uncertainty and divergence is therefore to be expected. In the study, compassion was understood to include components of benevolence, kindness, caring and empathy.

Some of the 16 meanings of compassion were: "show understanding about how they [the patients] are feeling/behaving", "compassion is caring and showing it" and "give time and listen". A subsequent question asked, "Is behaving and acting compassionately important to the goal of being an ethical psychiatric nurse?" More than 70% of the sample responded in the affirmative to this question. Responses included,

> I think behaving and acting compassionately is a goal of being a human but particularly for nurses, caring for vulnerable people.

Some nurses were uncertain about this question, for example,

> for the most part, behaving and acting compassionately is a major part of a psychiatric nurse's role, but in some instances this may not be appropriate.

And another nurse answered in the negative to this question, saying

> on occasions, because of my professional attitudes and position, despite not always feeling compassionate, I can fulfil this goal.

In Chapter 2, I examined the feeling of vulnerability that patients often experience. For the nurse in the first quote, being compassionate is necessary because of such vulnerability. Two points need noting regarding the second and third quotes above. In relation to the second quote, there is the question of the appropriateness of one's feelings and emotions. This is a difficult issue. It partly concerns whether nurses believe they should be 'patient-focused' or 'task-focused'. Some nurses worry that being patient-focused involves the need to form close relationships with patients. Such nurses might fear that excessively close relationships go beyond the boundaries of a 'professional' nurse-patient relationship. Nurses who hold this view might believe that overly close relationships jeopardize the 'professional' or 'ethical' status of the nurse. In this Delphi study, several nurses mentioned this latter point; nurses described colleagues as 'unethical' if such 'overly close' relationships developed. It might be fruitful to ask nurses to describe the sorts of situations hinted at above where 'in some instances' it is inappropriate to be compassionate. My second point is in relation to the third quote above. It is not clear what this nurse means by 'professional attitudes and position'. On a positive note, this nurse is honest in admitting that sometimes she lacks compassion for a particular patient. But despite this, she believes that she can still be an 'ethical' nurse. This response helps to bring out the distinction between actions and feelings. On the one hand, this nurse, acting perhaps from the obligation of beneficence, does benefit the patient. For example, she may provide him with analgesia for a headache or administer a psychotropic injection to reduce symptoms of mania. These examples are beneficent actions. But, on the other hand, these actions are according to this nurse, carried out without the *feeling* of compassion or without this nurse *being* compassionate. The

motive is one of duty rather than virtue. Actions might appear beneficent and the effects of these actions might benefit the patient. But in terms of motive, character traits and the quality of the interpersonal response, this is different from acting, thinking and feeling from the virtue of compassion.

A compassionate nurse will have compassionate thoughts and feelings. Furthermore, compassion demands action from its possessor. Thus the compassionate thoughts and feelings will motivate the nurse to respond in ways that show compassion. Possessing the virtue of compassion gives content and meaning to nurses' actions and thoughts. According to Lutzen and Barbosa da Silva[31], compassion is an active virtue; others include courage and trust. Active virtues, including compassion, "motivate the agent to the appropriate action in order to help the dependent patient".[32] Being a compassionate nurse will involve the desire to understand what is troubling a patient, the desire to spend time with a patient, listen to the patient's lived experience of the illness and the desire to ask questions so that the nurse can begin to make sense of the patient's lived experience. Showing compassion helps develop a bond with the patient. If nurses act, think and feel in compassionate ways, then the helping relationship is promoted. Other virtues such as trustworthiness between the patient and nurse can also be promoted. Furthermore, because compassion serves the good of others, it links to another virtue, namely, justice.[33]

This description of compassion has established a picture of what a compassionate nurse is like, what she feels and does. Character traits that I view as moral virtues might be seen as emotions by other thinkers. It might be concluded that compassion is an emotion. However, Von Dietze and Orb claim that compassion is a moral virtue with an emotional element. According to these thinkers, compassion also includes a rational dimension: "at its core is the notion of deliberate altruistic participation in another person's suffering".[34]

I realize, however, that it is not easy to identify, cultivate and habitually exercise the virtues, let alone do so for morally good reasons. Compassion is no exception, as Nouwen, McNeill and Morrison suggest

> Compassion asks us to go where it hurts, to enter into places of pain, to share in brokenness, fear, confusion and anguish..... compassion means full immersion in the condition of being human.[35]

In Chapter 3, I conceived a virtue as an admirable character trait, deserving praise and admiration from others, which is habitually exercised and helps its possessor and others to fare well in life. Based on this conception, I view compassion as a moral virtue.[36] Compassion is an example of an other-regarding or altruistic[37] virtue because the exercise of compassion helps others to a greater degree than its possessor. Compassion is a moral virtue needed by nurses to develop and sustain a helping relationship between themselves and patients. Compassionate care is an example of morally virtuous, that is, morally excellent care.

**Compassion and caring**

Compassion is for some an important aspect of 'successful'[38] care. What is the relationship between caring and compassion? The terms 'caring' and 'care' have been used several times in this thesis. The notion of 'caring' appears of fundamental importance in nursing and is necessary to describe the work of nurses. However, like other concepts such as 'best interests' caring is poorly conceptualized. It is difficult to move past a basic understanding, for example, 'its what we, as nurses, do'. A distinction has been made between 'caring for' and 'caring about'.[39] The former suggests a deontic foundation, a more distanced type of caring where the care is perhaps not 'patient-focused'. 'Caring about' sounds more inclusive, a more developed and wide ranging form of care where the carer focuses on a greater number of, or a more diverse set of, concerns. And, as noted in Chapter 3, Barker

talks about 'caring with', which suggests a more patient-centred collaborative sense of caring.

I believe that 'caring' represents an attitude about someone or something in the world. For example, 'I care for Carol' or 'I care about music'. The meaning attributed to the term 'care' is usually a positive one. For instance, if I overheard someone on a bus saying 'John cares a lot for Sally', without knowing anything about John I might think that John was a nice or a good person. In other words, the term 'care' results in a positive response in others. But I suggest because care is an attitudinal term, it needs qualification to bring out its real meaning. For example, according to the nurse who participated in the aforementioned Delphi study[40], it is possible to care without compassion. Reflecting on my clinical experience, I can recall nurses who went about their work efficiently. However I do not remember observing much compassionate care from these nurses. I suggest that the use of 'care' and 'caring' needs to be supplemented by another term; indeed I think in many cases the addition of a virtue term clarifies its meaning. For example, 'I care *justly* about Sam' or 'I am caring *patiently* for Jake'. Perhaps if a virtue term does not make sense, then an adjective or adverb might suffice. For instance, returning to the man on the bus 'John cares *passionately* for Sally'.

From the above, it should be clear that I reject the claim that caring is a virtue.[41] I believe that caring is not a morally admirable character trait that helps its possessor and others to fare well. Rather it is an attitude about someone or something in the world. Furthermore, I reject the idea that 'care' is sufficient for leading morally good lives, as it is possible to care in ways that are not morally good.

I shall now briefly describe the important role played by two more moral virtues, namely courage and respectfulness.

**Courage and advocacy**

The literature on advocacy and the role of the nurse as patient advocate is plentiful [42]. According to the obligation-based view, nurses ought to act in accordance with the obligations of beneficence and respect for patients' autonomy. This includes promoting and protecting patients' needs, interests and wishes. In reality, being an advocate for a patient can entail putting the interests of the patient ahead of one's own. An example is defending and promoting the wishes of a patient with cancer when these oppose the views put forward by the consultant.[43] Nurses who act as advocates can, depending upon the precise circumstances, leave themselves vulnerable to professional dispute and emotional distress. Therefore, one of the character traits needed to be a successful advocate is courage. One can call this moral courage, bravery or plain 'guts'. Irrespective of the nomenclature, people need courage to get through life. Ignoring military courage, courage helps one to endure the hostilities that daily life can provide. Women require courage to go through pregnancy. In general, people need to exercise courage for self-protection.[44] Possessing courage does not come naturally to everyone. I have noted that inculcating the virtues is sometimes far from simple. Cultivating and exercising courage requires nurses to *want* to help patients in distress. Without such desires, nurses would be less inclined to put themselves in the potentially vulnerable and dangerous position that being an advocate can demand.

I shall not discuss the arguments for and against nurses acting as advocates for patients. Suffice it to say that there are good reasons why nurses are not suitably placed to make effective advocates.[45] Despite these arguments, it remains clear that a nurse will at least on some occasions wish to act as an advocate for a patient. If this is so, then the nurse will require the virtue of courage in order to be an effective advocate and help promote the patient's needs and interests. Typically, obligation-based moral theories fail to discuss the character traits needed to be an effective

advocate. This is a major oversight and one that can be thoroughly addressed by the virtue-based approach to morality.

**Respectfulness and empowerment**

As noted in Chapter 2, the notion of empowerment is heavily debated in the literature. However, generally such debate fails to centre on an examination of the sorts of character traits that nurses require if they are to empower patients. Nurses will not be able to empower patients if they lack certain traits of character, for example, respectfulness; I suggest that other important virtues needed to help a nurse empower a patient include patience, tolerance and courage. The obligation-based view states that nurses ought to act in accordance with the principle of respect for a patient's autonomous wishes. While this instruction might provide some degree of action guidance, especially for a novice nurse, it seems to me that it remains crucial to debate and examine the moral character of the nurse. After all, nurses are not robots. How obligations are perceived, interpreted and applied concerns the kind of person one is. The latter is a core feature of the virtue-based approach to morality. The virtue of respectfulness can be examined and a nurse can understand the kinds of actions, thoughts and feelings fostered by this virtue. For example, a nurse asks a patient with asthma certain specific questions about his medications because she sees that his hands are shaking more than usual. She listens attentively to his responses and relays such information to a doctor. The result is that the patient is prescribed a reduced dosage of vasodilator, which is causing the shakes. As a result, this patient feels more in control of his treatment and a little more empowered.

In the next section, I describe the three features of the virtue-based approach to moral decision making in nursing practice. The first feature is the exercise of moral virtues. The conception of compassion outlined is utilized to facilitate understanding.

The second feature is the use of judgment and the use of moral wisdom is the third feature of the virtue-based approach.

## Virtue-based moral decision-making

### The virtue of compassion

Imagine a nurse who is caring for a male patient with Parkinson's disease (PD). Because this disease affects neuromuscular transmission, problems of living result, for example, one needs help with activities of living such as washing, dressing, eating and walking. Jack has PD and lives alone at home. A community nurse visits him each day. Jack's favourite nurse is Carol. Jack likes Carol because he believes that she understands him better than some of the other nurses. If pressed, Jack thinks that Carol is a kind nurse who shows him compassion.

Carol is disposed to carry out beneficent actions that help Jack. She tries hard to meet all of Jack's needs, including his emotional needs. Although Carol has a busy daily schedule, she enjoys spending time with Jack. She asks him if the new sinemet medication is working, she asks him about his son who lives in Australia and she asks him if the care staff have done his shopping. Jack replies that the new tablets are beginning to work, his son is doing well and his shopping was done yesterday. Conversing with Jack can take a considerable time, especially if Jack is having a bad day and his speech is slurred. It seems to Jack that Carol is also a very patient nurse. From Carol's perspective, she wants to get to know Jack so that, in part, she can understand his illness and its effects on his life. Carol hopes that she can help Jack to better adapt to the PD, especially managing his muscle tremors[46] more effectively.

Carol is motivated from deep inside to show kindness to her patients. Carol's parents and her friends describe her as a genuinely kind person. Kindness is, for Carol, one of the core values of being a good caring nurse. Carol aims to understand Jack's predicament. She thinks about his situation when she visits him. Moreover, when Carol leaves his house she imagines what it might be like to be unable to walk more than 30 metres without tumbling to the floor, what it might be like dribbling when trying to eat and what it might be like to be unable to get dressed nearly every morning of one's life. Carol believes that being compassionate includes a desire to understand Jack's individual needs and his distress. She is kind and aims to be compassionate not because other people tell her to be or because the NMC code of conduct[47] demands this from her. Instead she is habitually kind, because it is part of whom she is as a person. Carol believes that patients, like Jack, do better when she demonstrates kindness in her work.

The above scenario is not meant to read as a caricature of a caring patient-focused nurse, although it is possible to read it in this way. It seems to me that one of the points about so-called holistic and patient-centred nursing care is that if these notions are to be any more than mere buzzwords or slogans, then nurses need to demonstrate the virtues. One aim of the above scenario is to show how it is possible for a nurse to think about the meaning of compassion and apply it to patient care. Moreover, the thoughts and feelings of patients and nurses involved are taken into account as well as actions. Carol demonstrates compassion towards Jack. But she is also patient towards him; she understands the effects that PD can have on Jack. For instance, the fact that it sometimes takes him a long time before he can speak. It is important to clarify that a nurse who advocates the virtue-based approach to morality is highly unlikely to exercise just one virtue. This example helps to show that altruistic virtues such as compassion and patience are interrelated.

**The use of judgment and moral wisdom in nursing practice**

Virtue-based moral decision-making acknowledges and encourages the use of judgment and moral wisdom - moral perception, moral sensitivity and moral imagination.

Suppose Carol visits Jack one morning as usual. However, this morning Jack does not wish to get out of bed. Carol observes signs of pain and discomfort in Jack's face. She asks him whether he slept well, but muscle tremors and spasms kept him awake most of the night. Jack wants to lie in bed for an hour or two longer. Carol is however concerned that Jack may develop a sacral pressure sore, as his skin is already very red. Having perceived Jack's distress and established his lack of sleep, Carol thinks carefully about how she should respond to Jack's needs. On the one hand, he wants to sleep for an hour or two, which is important given the bad night he has had. One the other hand, Carol does not wish Jack to develop a pressure sore that will cause further physical and emotional distress. Carol thinks about how she might feel given the circumstances. She also takes into account the wide range of morally relevant features listed earlier. This wide range of information and the knowledge she has of Jack's condition and character enables Carol to make a judgment. She decides that on this occasion she will ask Jack if she can move his position in the bed. She explains to Jack the risk of pressure sore development. He understands this and they mutually agree that Jack will lie on his left side. Carol offers to return in an hour or so after seeing another patient. Before she leaves, Carol gives Jack an extra dose of Sinemet[48] to relieve muscle tremors. Just over an hour later, Carol returns to visit Jack. He is much happier because his spasms have abated and he has slept well for the past hour.

It has been noted how the virtue-based approach does not over focus on actions. Instead it also acknowledges and examines the thoughts and feelings of patients and nurses. It aims to help patients survive and recover from illness. In an attempt to find a wide range of ways to help patients through and beyond illness, the virtue-based approach encourages the use of reflection and critical thinking skills. For example, being kind and compassionate enables a nurse to think about a wide range of treatments including pharmacological ones. The obligation-based moral approach does not necessarily preclude this aspect of practice. But the virtue-based approach promotes and encourages the development of a helping relationship and this in turn fosters reflection about the needs and interests of patients. If the approach taken by a nurse is limited to acting according to moral obligations, rules and principles then the thoughts and feelings of both nurses and patients will not take centre stage. If a nurse allows only actions and obligations to guide her practice, then it seems to me that she is potentially limiting the range of practices and activities that might in some way help a patient.

An example might help. Suppose a patient has chronic back pain that is secondary to cancer. The virtue-based approach encourages the nurse to use moral wisdom – moral perception, sensitivity and imagination – to reveal information about the patient that might otherwise remain unknown. In this case, the nurse spends considerable time[49] with the patient in order to evaluate his pain and the effectiveness of the prescribed morphine. Through conversation, asking open ended questions, the willingness and ability to listen to the patient's responses and the desire to understand the patient's lived experience of cancer and bone pain, it becomes clear that the patient's pain is not well controlled. He is also suffering from severe constipation, which is recognized as an adverse side effect of morphine.[50] The nurse is intent on helping the patient to fare as well as possible through the nightmare of cancer, both the disease itself and its treatment. She therefore conveys to a medic

that the patient's pain is poorly controlled and that he is suffering from constipation. The nurse makes it clear to the medic how much distress the patient is in. The morphine is soon replaced with Fentanyl [51], which proves more effective in controlling the patient's pain, plus regular bowel movements are soon re-established. It is sometimes not possible – perhaps due to the intensity of the work and an insufficient number of nurses - to spend a lot of time getting to know a patient's needs. At other times, spending time with patients might be possible, but literature has already shown that nurses spend minimal time in direct contact with patients. Hence, it is morally admirable that a nurse should act, think and feel from the virtues of patience and kindness as in this scenario. But the impact of the virtues is clear to see: this nurse was able to promote the patient's quality of life and I would suggest that these kinds of interventions are often the ones that patients tend to remember.

## Merits of the virtue-based approach

In Chapters 3 and 5, I identified and examined some of the merits of the virtue-based approach to morality and virtue ethics from the perspective of general ethics. In this chapter, I have considered other merits of this approach, for example, how it promotes the use of judgment and moral wisdom and how these morally important features can help nurses make morally good judgments. I shall now summarize and perhaps clarify some of these important merits.

### The language of the virtues

Nurses utilize the language of the virtues and vices on a daily basis. For example, words such as 'care', 'fair', 'well', 'just' and 'good' are all aretaic (virtue and vice) terms.[52] It therefore seems sensible to claim that the language used by nurses should be utilized in the moral theory that they adopt to guide their practice. This claim provides a reason why nurses should consider utilizing the virtue-based approach and virtue ethics instead of obligation-based ethics.

**Adequate action-guidance**

The above is more important than it might at first appear. Supported in part by Hursthouse's[53] v-rules thesis (Chapter 5), such aretaic terms do provide a good degree – breadth and depth – of action guidance. In other words, by thinking hard about words such as 'kind' nurses can get a sense of what these words mean. For instance, Tom is 15 years old. He is bored, having been a patient on an orthopaedic ward for 6 weeks. He is in traction because he has a serious complicated lower limb fracture. If I think about the meaning of 'kindness', then I imagine some of the things that I could do that are kind deeds. From conversing with Tom, I know that he enjoys reading music magazines. Within a couple of hours, I have obtained some music magazines from the hospital library. When I visit Tom he appears genuinely surprised and grateful. He thanks me for my kindness and thoughtfulness.

Thus, through reflection of previous and current experiences the sorts of actions, thoughts and feelings that aretaic words can conjure up in one's imagination can become quite clear. As noted, thinking about the meaning and content of aretaic terms and exercising the virtues provides the moral motive for action. It has been noted in Chapter 5 that virtue ethics is charged with not being able to provide adequate action guidance. This is held to be a serious flaw of virtue ethics and it is one reason why a strong virtue ethics is often held to be non-viable (Chapter 5). I reject this claim and assert that a strong virtue ethics – one that provides adequate action-guidance for nurses – is both possible and plausible. As such, it demands increased scholarly attention and an acknowledgement that it provides a serious moral alternative to the traditional obligation-based moral theories of consequentialism and deontology.

**The virtue-based approach, consequences and other morally relevant features**

The virtue-based approach does not ignore or even minimize the crucial notion of consequences in the moral life of patients and nurses. As noted in Chapter 4, the idea of consequences/outcomes/results is fundamentally important in everyday life. Thus, consequences are taken into account by the virtue-based approach. However, virtue ethics does not over focus on the importance of consequences at the expense of other morally important features. Virtue ethics accommodates and debates several features of morality ignored by obligation-based theories. These have been discussed in detail in Chapter 5. Two of these are: an examination of the moral character of people (both nurses and patients) and the need to develop and sustain a virtue-based helping relationship to enable patients to survive, recover and fare well.

**The virtue-based approach and the role of emotions in morality**

Another morally relevant feature that is taken into account by the virtue-based approach is the important role played by emotions such as distress, fear, anxiety, vulnerability, guilt and remorse in the moral life of nurses and patients. One of the main points is that it is morally appropriate for nurses to *feel* different emotions in their daily work. These emotions are often distressing and unpleasant. First, suppose a nurse has withheld information from a patient with terminal illness because the patient's relatives believe she could not cope. Second, suppose a nurse tells a patient that information will be kept secret and the patient who trusts the nurse tells her that upon discharge he will self-harm. The nurse thinks that it will be best for the patient if she passes this information on to the consultant. Or, third, perhaps a nurse lies to a paralysed patient when asked if he will ever walk again. The nurse cannot bear to tell the patient whom she is close to that he will never walk again. In each example, it is morally appropriate that the nurse should feel certain emotions as a result of being involved. I suggest that in all three examples, the nurse would feel emotionally upset, guilty and worried concerning the patient's response upon finding

out the truth. Because the virtue-based approach focuses upon the kind of nurse one is, it examines the traits that in part make a morally good nurse. This examination – of good and bad character traits – necessitates and promotes self-reflection. Because the emphasis is not solely on actions, the virtue-based approach and virtue ethics takes emotions and feelings into account and recognizes their value in terms of their contribution to the moral lives of patients and nurses.

**The virtue-based approach and resolving moral dilemmas**

The virtue-based approach does not over focus on actions. It examines the thoughts, feelings and emotions experienced by nurses and ill patients. In part because of the distinction noted by Hursthouse[54] (Chapter 4) between two possible ways of using 'right moral decision/morally right action' compared with the obligation-based approach there is less emphasis placed upon finding solutions to moral problems and dilemmas. An assumption is not made that all moral dilemmas are resolvable. Unlike the obligation-based view, the aim is not to do the right thing. The aim is to act well, that is, from the virtues; actions, thoughts and feelings motivated from the virtues will be morally good. Nurses ought to strive towards achieving morally good interactions and responses with patients. When a nurse is involved in morally complex, tense situations, for example, when a patient is coerced into having ECT for depression against his wishes, the morally appropriate response from a virtuous nurse is to feel moral remainder. This is because involvement in such horrible situations should produce certain responses in a nurse, for example, a nurse might feel regret and remorse for her involvement including the things she said and did. As was noted in Chapter 4, in even more terrible situations, which Hursthouse refers to as irresolvable and tragic dilemmas, the lives of those involved including nurses and patients will end up being marred in some way. This claim provides a reason why a plausible and adequate nursing ethics needs to take the role of emotions/moral remainder into

account. Obligation-based moral theories in nursing are incomplete and hence inadequate because they neglect this morally important feature.

**The virtue-based approach and moral education**

The question of how to educate the young to be good persons is clearly an important one. In nursing, it is necessary to consider how student nurses can develop to be morally good nurses. Rather strangely, the obligation-based approach fails to sufficiently debate these questions. It is though people of any age – the immature and mature – just *will* be able to act in accordance with moral obligations. In contrast, virtue ethics asks questions concerning the moral education of the young. In examining such issues as learning from role models and habituation of moral and clinical excellences, the virtue-based approach and virtue ethics provides a good starting point for further exploration of issues concerning the moral education of nurses (I discuss the topic of moral education further in the 'Conclusions').

**The virtue-based approach, narrative accounts of illness and patient-centred care**

The virtue-based approach to morality including the idea of a virtue-based helping relationship promotes a narrative and relational account of a patient's lived experience of illness. As noted, patients feel a range of emotions including fear, anxiety, powerlessness and vulnerability and the virtue-based approach recognizes the presence of such emotions. Illness can create these emotions and the process of hospitalization can intensify these feelings. In part, because intrapersonal and interpersonal responses are examined and developed, it seems to me that the virtue-based approach recognizes the value and promotes the ideal of patient-centred and holistic care. In Chapter 2, literature was examined that indicates that (at least) some patients and some patients' relatives define 'high' quality care in terms that I would call virtue-based care. For example, high or good quality care involves nurses being

gentle, patient, honest and kind towards patients. I believe that good nursing care and the exercise of the moral virtues is synonymous.

**The virtue-based approach and the use of judgment and moral wisdom in moral decision-making**

In my view one of the most notable merits of the virtue-based approach to morality is its acceptance and promotion of the use of judgment and moral wisdom in moral decision-making. Earlier in this Chapter, I examined both judgment and the associated notion of moral wisdom and applied it to nursing practice. In short, judgment is a complex process with the end result that a decision/choice is made. A wide range of morally relevant features is taken into account. While deontological moral rules are useful, conflicts frequently occur. Nurses should perceive and assimilate precise pieces of information and examine some of the complexities of specific morally dense situations. Judgment is required to work through this assemblage of information. Moral wisdom – moral perception, moral sensitivity and moral imagination – is utilized in tandem with judgment in an attempt to make morally good decisions. While this is problematic (to be discussed later in the 'Problems' section), the virtue-based approach, unlike obligation-based moral theories, construes moral decision making as difficult. In this respect, the virtue-based approach describes and reflects more accurately the work of clinical nurses including the innumerable morally tense and complicated moral tensions and conflicts that arise in contemporary nursing practice.

**The virtue-based approach and reasons for action**

Another advantageous aspect of the virtue-based approach requires some discussion, namely, reasons for action.

'Reasons for action' is a richly documented philosophical topic.[55] From a virtue-based perspective, Hursthouse has examined reasons for action and moral motivation in relation to a woman's reasons for wanting an abortion.[56] Moral rights are usually given as the framework for discussing the morality of abortion. But as Hursthouse claims "in exercising a moral right, I can do something cruel, or callous, or selfish, ....inconsiderate, ....dishonest".[57] In other words, people can act viciously (I noted that people can exercise rights virtuously or viciously in Chapter 4). Pregnancy and childbirth are very important states of being for many, though not all, women. It is important to recognize and contextualize pregnancy and childbirth within the whole narrative of a woman's life. The woman's needs, interests, values and life plans need to be identified and taken into account in decision making. It might be a morally kind act for a woman who never wanted children to abort, if after prolonged deliberation she feels strongly that she could not give a child a caring and happy environment in which to live well. Acting from kindness is an example of acting morally well. Conversely, one's reason for wanting an abortion might turn on, for example, selfishness. For example, a woman says 'I want an abortion because I want to go out shopping and having a child to care for would spoil my enjoyment of life'. Or perhaps the reason for action might be dishonesty as in 'I want an abortion because the father of the child is not my husband, and I don't want my husband to find out'.

The above reasoning can be applied to nursing. Two examples from mental health practice are: (A) Elizabeth refuses her psychotropic medications and (B) John wants to be released from the mental health unit. These two examples serve as illustrations that facilitate an explication of the topic of reasons for action. But, it seems to me that one of the many strengths of the virtue-based approach is that it promotes an examination of the particulars of each situation. In nursing practice, complex and subtle issues will need to be identified.

In (A), Elizabeth might refuse to take her psychotropic medications because they make her feel nauseous and very tired. She is really keen to write a letter thanking a friend for a recent present. It is several days since the present arrived, but Elizabeth's depression prevented her from responding to her friend. Now, she is in a rush to get the letter written and posted. Her medications make her feel unwell, which means in turn she does not feel able to concentrate on writing the letter. This is why she does not want to take her medications. Elizabeth's motive is that she wants to demonstrate gratitude to one of her closest friends, someone she has known for over 30 years. She wishes to maintain a close friendship and she values loyalty. Her reasons for action (refusal of medications) are grounded in the virtues of respectfulness and loyalty (perhaps others too).

However, in (B) above, John wants to be released from the mental health unit, because he has 'a score to settle' with someone whom he feels has let him down. One day John is heard to mutter 'I'm going to show him who's boss' and 'I'll teach him a lesson he'll never forget'. It is plausible to think that his reason for wanting to leave the unit concerns vices such as physical/verbal aggression and cruelty.

## Problems of the virtue-based approach in nursing practice

In this section, I highlight some of the major problems with the virtue-based approach. These have been noted in Chapters 3 and 5, but here I explore these problems in more detail and in the context of contemporary nursing practice.

### Assumptions about virtues and goodness

It was noted in Chapter 3 that an assumption is made regarding moral virtues being morally good traits of character. For example, that it is morally good to be honest. Or that by being honest one can lead a good life. However, the claim that a certain character trait, for example honesty, is a virtue is made because it meets with a

specific conception of a virtue. The authorities for such conceptions include some of Western philosophy's most respected thinkers including Aristotle[58] and in contemporary virtue ethics Slote[59] and Hursthouse.[60] I am not saying that such conceptions are *necessarily* well argued. Rather, one needs to consider whether the character trait under the spotlight satisfies the criteria given in the conception of a virtue that is utilized. My conception was given in Chapter 3, but to repeat: a virtue is a character trait that is habitually performed, which disposes the possessor to act, think and feel in morally good ways. A virtue is a morally excellent trait that deserves praise and admiration from others.

Nurses who display the virtues, especially the other-regarding virtues such as kindness and generosity, will have a positive impact on the lives of patients. It has been noted (Chapter 2) how some empirical research indicates that patients *feel* virtuous care, for instance, the kindness of a nurse. It has also been noted how some patient's perceptions of 'high' and 'good' quality care concern nurses exercising moral virtues. Besides kindness and generosity, moral virtues important in nursing include fairness, patience, and courage.

**Assumptions about the meaning of 'virtuous'**

It is possible that a number of people, including nurses, view the language of the virtues as old fashioned. For example, if one is described as 'virtuous' then it can be understood to mean 'prissy' or 'prudish'. This possibility might deter a nurse from learning more about the virtue-based approach. Clearly, there is a need to teach the virtue-based approach and virtue ethics in nurse education. Evidence suggests that this does not always happen.[61]

Part of the reason why the virtues can be seen in the above negative way is because of the history of nursing, especially the influence of Nightingale. She wanted nurses

to be good, with high moral character. The virtues in Nightingale's era of nursing were obedience and subservience, because the nurse's role consisted in following the physician's orders. This shows how the meanings of virtues change over time and differ between gender and cultures. Perhaps some thinkers and clinical nurses still think of the virtues - if indeed they think of them at all – as submissive traits of character. If so, then it seems to me that this provides even more reason to educate nurses about the virtues.

**Identifying the virtues**

The charge of moral relativism can be levelled at the virtue-based approach to morality. It is alleged that since virtues are human character traits it follows that disagreement will arise in identifying which traits are virtues. I accept that people will produce lists of different virtues. This will happen in part because human needs, interests and values are distinct. Because of the complexity of human lives, I find it difficult to believe that an advocate of the virtue-based approach would lead his life according to *just* one virtue. Irrespective of whether a virtue such as justice is considered to be fundamentally important to the moral life, it seems to me that one would also realize the importance of other moral virtues, such as courage, respectfulness and kindness. This is a positive aspect of the virtue-based approach; human lives are complex, multifaceted and multidimensional, thus many different virtues are necessary to lead morally good lives.

I also accept that people might prioritize virtues differently, for instance, one person thinks that kindness is much more important than patience. Some people prioritize the moral importance of obligations; it was noted in Chapter 4 how 'respect for autonomy' appears to be the predominant moral obligation (especially in the current climate of empowering patients). Likewise, perhaps, some people might believe in a 'fundamental' virtue, such as justice. The point is that some virtues will be more

appropriate and applicable than others depending on particular situations and roles. For example, there are 10 nurses on a medical ward. It might be thought that all of the nurses would agree that compassion and honesty are key virtues, which need to be exercised in patient care. But I believe that this is overly optimistic. Why should 10 different people, each with their own unique values about nursing practice, not to mention distinct needs and interests, agree on something as complicated as this? Instead, I would expect some disagreement. The nurses hold a team meeting. Perhaps 5 nurses agree that compassion and honesty are really important virtues. Another 3 nurses point out that respectfulness, especially given the current emphasis on patient-centred care, is a crucial virtue to inculcate. The remaining 2 nurses bicker among themselves and fail to reach any firm conclusions. Furthermore, 4 weeks later at the next team meeting, it transpires that most of the nurses have changed their minds! The 10 nurses now feel that all of the virtues mentioned 4 weeks earlier are equally important. Therefore all of these virtues should be demonstrated in the delivery of patient care. The nurses agree that depending on issues such as the nature of the nursing activity, the needs and interests of the patient and the kind of nurse one wishes to be in a given interaction, some virtues will be more important than others.

In Chapter 2, it was noted how individual nurses view their roles and the nature and ends of nursing in different ways, even though some general agreement is reached. However I reject the claim that disagreement would cause insurmountable problems. Acting from the virtue-based approach entails certain phenomenon. For example, moral wisdom and judgment would be utilized, the virtue-based helping relationship would be developed, patient-centred care would be promoted, and the virtues would serve as the nurse's motives. Given this, it seems to me that identifying and prioritizing different virtues is not especially problematic for nurses.

**Why should nurses be virtuous when nursing patients who have committed deplorable acts?**

This question is very important and raises serious issues about reasons for acting from the virtues; especially the idea that nurses should be just and impartial.

Examples of deplorable acts include rape and child abuse. Rapists and child abusers often come into contact with forensic psychiatry services. The deontic approach instructs nurses to abide by certain obligations, for example, the four principles approach examined in Chapter 4. These moral demands apply irrespective of what the patient has done. The obligation of beneficence means that nurses are obliged to benefit patients. Again, this applies whether one likes and admires the patient or whether one dislikes and is repulsed by the patient. On the surface, this appears to be reasonable. However, on an emotional level it is far from simple to *always* apply such moral demands. One of the problems is that obligations are external concepts. As such, it might be difficult for a nurse who is angry with and repulsed by a patient to act from beneficence when this is not how she *feels* towards the patient.

It is true to say that humans compare and evaluate each other's acts and thoughts. If these are judged to be deplorable then it fails to make sense – it is not part of the human condition – to like and admire the perpetrators of such acts. Because rape and child abuse are horrendous, vicious crimes that violate human rights, I believe it is fair to claim that most people think rape and child abuse are deplorable acts. As such, the perpetrators might well be despised for their actions.

In response to the question 'why should nurses be virtuous when nursing patients who have committed deplorable acts?', I shall make 4 claims.

First, it is the virtue-based approach that people utilize when they describe acts such as rape and child abuse as *deplorable* and the perpetrator as *despicable*. These terms are aretaic, that is, they describe behaviours and thoughts motivated from the virtues or in this case the vices. These kinds of terms can be used to describe and evaluate a person's moral character. Instead of admiring or praising one for displaying the virtues, a natural conclusion to draw is that someone who rapes another person or abuses children is to be despised. Such aretaic terms are, as Hursthouse[62] and Benn[63] claim, common and very useful. The deontic approach fails to provide words that possess such descriptive power. Using such aretaic terms can be therapeutic and cathartic. The use of these kinds of terms and subsequent discussion can facilitate the relief of raw emotions such as anger and hatred in nurses who treat and care for rapists and child abusers.

My second response is that nurses and other practitioners who treat and care for rapists and child abusers should aim to be just and compassionate. This will not be an easy thing to do. Raw emotions will probably make this difficult to do, at least on a habitual basis. However, the virtue-based approach recognizes the importance of the emotions in the moral life. The deontic approach fails to sufficiently take the emotions of nurses into account. Nurses might feel a range of strong emotions such as anger, hatred, rage, and perhaps vengeance. The virtue-based approach recognizes these emotions as real. These emotions are not conveniently brushed aside as 'unethical' or 'wrong', because they might motivate unfair actions for example. The virtue-based approach acknowledges and accommodates such negative emotions in nurses who treat and care for perpetrators of deplorable deeds.

My third response is to claim that in nursing people who have carried out despicable and evil deeds, one is reminded of the dark side of humanity. One is presented with a vivid picture of just how vicious people can be and what terrible deeds people are

capable of doing. It seems to me that this fact about human nature provides further reason for people to focus on inculcating the virtues.

My final response regarding this serious question is not at all intended to defend the despicable and deplorable acts committed by perpetrators of rape and child abuse. However, it is a response that I believe the virtue-based approach would make because it promotes reflection concerning reasons for action. This is that nurses should try to understand why some people perform deplorable deeds. Perhaps an abuser was abused as a child. Perhaps there is evidence of diminished responsibility. The virtue-based approach holds that people can cultivate the virtues, although this requires consistent hard work and determination. One claim that comes out of this is that it is possible for people to change their character if they want to badly enough. It might be possible then for some people who have carried out despicable deeds to change especially with virtuous care and effective treatment. I remain uncertain however about the empirical evidence that might support or deny this possibility. I can hear forensic nurses saying 'only someone who has never met or worked with perpetrators of rape and child abuse would say something like that'. Nevertheless, it is a view that I think the virtue-based approach would advocate. Where would the boundaries be drawn if nurses (and other practitioners) could treat patients as they like? For example, is it morally justifiable for a homophobic nurse to refuse to care for a homosexual? Is it morally justifiable for a racist Caucasian to refuse to care for an African-American? Justice both as a moral principle and a moral virtue would be shattered if one's values and emotions went unchecked.

**The problem of exercising a virtue to an excessive degree**

Aristotle's 'doctrine of the mean' is sometimes taken to mean that persons need to moderate their feelings, for example, no one should ever feel extreme anger or love. I concur with Norman[64] who takes the mean to concern the relationship between

reason and emotions/feelings. As noted, experiencing emotions is an important part of the reality of contemporary nursing practice. Moreover, it is not always simple for nurses to work through one's emotions and hit the mean when it comes to exercising the virtues. For example, although a nurse wants to be kind, she also realizes that some patients can be manipulative; showing too much kindness can then prove counter-productive. Another example concerns the virtue of honesty. If a nurse on a mental health ward was always *completely* honest this might lead to difficult situations for the other nurses on the ward. Suppose a patient asks about the side effects of a medication and the honest nurse describes a long list of such side effects. But, on another occasion a different nurse responds to the same question, only he decides not to reveal some of the side effects. He does so because he does not wish to deter the patient from taking the medication, as it is having beneficent effects.[65] Also, imagine if a nurse was to tell the truth (or more accurately, the 'truth' as far as she was concerned) to a patient prior to a surgical procedure. The patient asks about 'possible complications' and discovers that there are several, including a particularly high likelihood of haemorrhage and post-operative infection. Might this worrying information deter the patient from undergoing surgery?

Finding the mean involves the use of judgment and moral wisdom, especially moral perception. Moral perception helps a nurse to see and discern meaning in a wide range of morally relevant features. Clinical information will also be taken into account, plus other relevant pieces of information that apply to the situation at hand. Moral perception helps to identify and clarify the morally relevant features of complex, morally tense situations.

The virtue-based approach focuses on developing morally good responses and interactions and developing and sustaining a helping relationship based on several moral virtues, for example, kindness, patience, trustworthiness and courage. If a

nurse practices (acts, thinks and feels) according to the virtue-based approach, then the importance of moral wisdom and judgment should be clearly understood. It seems to me that the virtue-based approach actually facilitates and heightens moral perception and moral sensitivity. Furthermore, the virtue-based nurse does not over focus on the nature and consequences of actions; neither does she assume that moral dilemmas are resolvable. The emphasis is not on discovering right and correct solutions to moral problems and dilemmas. Instead, the virtue-based nurse seeks to identify and reflect on the morally relevant features of specific interactions. Her general aim is to act, think and feel in morally excellent ways to help the patient survive illness, recover and fare well.

One might accuse the virtue-based approach of setting extremely high standards of behaviour for nurses. I accept that it is not always easy to be virtuous, for instance, kind, generous and patient especially on *every* occasion. However, it does not follow that the virtue-based nurse should always be, for example, (a) honest or (b) courageous. There will be many times when such behaviours should and do happen. It is, however, also clear that by using moral wisdom and judgment, a nurse will make a decision based on the morally (and clinically) relevant features of each situation or interaction. For example (a) a nurse decides to withhold some information about the side effects of a medication and (b) a nurse does not act as an advocate for a patient. In (a) the nurse thinks that the medication is helping the patient to recover from illness and fare well. Thus, she judges that, on this occasion, it will help the patient to recover if she continues to take the medication. Therefore a judgment is made that withholding a piece of information is a morally right action. Note, however, that in this situation the virtue-based nurse will feel moral remainder. This is because while this action might be morally right, it does not count as a morally good deed.

In (b) the patient is demanding cardiac surgery that is so risky the surgeon is unwilling to attempt it. Rather than being courageous, the nurse decides that it would be an example of acting badly, perhaps foolishly or naively, if she acted as an advocate for the patient on this occasion. The nurse judges that the surgeon is acting well. She decides that going ahead with this operation would be reckless. She also believes that the patient is being selfish because he is not thinking of his spouse's feelings. Therefore, to promote the patient's wishes on this occasion would be acting badly.

**Conflicts between virtues**

The above discussion regarding the use of judgment and moral wisdom is implicated in providing a response to another common criticism of the virtue-based approach to morality. This is that virtues conflict and a person has no way of knowing which virtue to exercise. This claim is intended as a serious objection of the virtue-based approach and virtue ethics.

First, I hold that conflicts between virtues are to be expected given the moral complexity of human lives. But critics[66] suggest that the conflict problem is a serious disadvantage of the virtue-based approach. The fact that there is no single rule or a decision procedure to follow is seen as a major flaw of the virtue-based approach. However, in my view, an adequate normative ethics should acknowledge that conflicts, whether between obligations or virtues, will arise especially given the subjective and value-laden moral complexities of human lives. This is particularly true within nursing practice, saturated as it is with innumerable dense, complex moral tensions.

Second, I have already discussed two points that relate to the claim 'when virtues conflict, a nurse has no way of knowing which virtue to exercise'. The first is that the

action-guidance available from thinking about the meaning and application of the virtues, for instance kindness, means that a nurse will have an idea of what to do. One can eliminate actions, thoughts and feelings that are unkind, cruel and callous (these are examples of acting from the vices). Then, reflection and use of moral imagination regarding the v-rule 'be kind' can help to conjure up examples of kind actions, thoughts and feelings that can be habitually exercised. The second related point is that a nurse might prioritize one virtue over another. For example, she believes that justice is more important than patience in delivering morally good patient care. If the conflict involves justice, then irrespective of the second virtue in question the nurse will have an idea of what to do and how to be. She will act in just ways and think and feel justly.

Third, what is a nurse to do given a situation in which she could either act from the virtues of respectfulness or justice? Return for a moment to the earlier example of Carol, the community nurse and Jack, the patient with PD. Although it was not made explicit, the two virtues of respectfulness and justice are in conflict in this scenario. The options were: should Carol get Jack out of bed or let him have another hour in bed? Carol acted from the virtue of respectfulness. She made this decision after conversing with Jack. She discovered that he had not slept well overnight and she respected his request to have another hour in bed. Carol utilized moral wisdom and judgment in her decision-making. On this occasion, with this set of morally (and clinically) relevant features, Carol believed that being respectful and leaving Jack in bed a little longer would help him to fare well. Carol reflected about justice and Jack's needs. She concluded that it would be unfair to insist that Jack should get out of bed. This is because on previous occasions Carol has respected other patient's views, some of whom also had PD and a sore sacrum. According to Carol, their needs appeared remarkably similar too. Therefore, if she had allowed these other patients to lie in bed longer, why ought she insist that Jack should get out of bed?

I noted earlier that situations in clinical practice often require more than one virtue to be exercised. The above is an example of this claim. This is because I believe that Carol understood that having a good sleep is a benevolent action. It is clear that Carol acted kindly. Another community nurse, perhaps one acting from the obligation of non-maleficence, might well have persuaded Jack that getting out of bed was better for him than remaining in bed. This second nurse might have told Jack that his sacrum was very red and sore. Therefore to prevent the development of a sacral pressure sore, it was more important to get Jack out of bed and relieve the pressure than allow him to have another hour in bed.

I need to make it clear, however, that I am not suggesting that a nurse who acts in accordance with an obligation, such as non-maleficence, is unable to act kindly. Instead, I think the point is that sometimes it can seem so important for a nurse to act from obligations (both moral and legal) that other morally important features are neglected. These include inculcating moral virtues, using moral wisdom, using judgment and realizing the important role played by the emotions in the moral lives of patients and nurses.

Finally, the virtues are excellences of character, admirable and praiseworthy traits that help their possessor and others to lead morally good lives. I understand that choosing between virtues can be problematic, these sorts of situations require a nurse to utilize judgment and moral wisdom. However, as long as the choice is between 2 (or more) virtues, then by definition subsequent actions, thoughts and feelings should be morally good and thus have a positive impact on the patient's life. For example, take justice and kindness. Both of these virtues aim to help the patient to fare well, but in different ways. Kind actions, thoughts and feelings will have a positive impact on the patient's well being. The same can be said of just actions, thoughts and feelings. The actual actions might be different, but both virtues will

contribute to a patient surviving and recovering from illness.

I end this section by suggesting another option in response to a conflict between two or more virtues. Depending on the particulars of the situation including the patient's physical and emotional needs, acting from the virtue of respectfulness means that the nurse could ask the patient for his views. The range of options could be outlined and the patient would be given the choice. Given certain caveats – for example, the patient is an adult with decision making capacity - it seems to me that in the current climate of promoting empowerment and collaborative and patient-centred care, this option is not as preposterous as it might at first appear.

## Conclusions

I have examined the crucial role played by judgment and moral wisdom in nurses' moral decision making. Obligation-based moral theories neglect these phenomena. Indeed, act-consequentialism with its single rule – maximize best consequences – holds that the use of judgment is not only unnecessary, it is a sign of a defective moral person.[67]

I have explained why the virtues should be inculcated. I have demonstrated how a nurse can exercise the moral virtues in patient care, for example, compassion. The general aim of the virtue-based approach is to help the patient to survive and recover from illness and fare well thereafter. At the core of this aim is the need to develop and sustain a virtue-based helping relationship. Besides compassion, nurses ought to inculcate other virtues such as courage, respectfulness, patience, justice, honesty and tolerance.

I characterized the three features of the virtue-based approach to moral decision-making in nursing practice. These are: (1) the exercise of moral virtues; (2) the use of judgment; and (3) the use of moral wisdom. The obligation-based view might pay homage to (1), but it seems to me that it ignores and derides the use of (2) and (3).

I have identified several problems associated with virtue ethics and the virtue-based approach to morality. These problems are well known in general ethics. I have discussed these problems in the context of contemporary nursing practice. My responses to these problems, especially the conflicts problem, have been explicated. I believe that these responses provide an adequate defence of the virtue-based approach. It needs to be noted that philosophers have been debating obligation-based theories since the 18$^{th}$ century and yet several problems still remain. I hope that with further scholarly work from moral philosophers and health care ethicists in virtue ethics and the virtue-based approach, some of the problems of the virtue-based approach will be further resolved. However, it seems to me that disagreement is a permanent and positive feature of philosophical enquiry and as such should be accepted and applauded.

Virtue ethics and the virtue-based approach have several merits that were described in Chapters 3 and 5. In this Chapter, I applied these merits to contemporary nursing practice. These merits include: nurses utilize the language of the virtues in clinical practice; adequate action guidance is provided from thinking hard about the v-rules and the virtue and vice terms; the role played by emotions in the moral lives of patients and nurses is taken seriously; empowerment and patient-centred care are effectively promoted; and the use of judgment and moral wisdom is recognized as being very important for nurses.

Such a virtue-based approach has distinct advantages for contemporary nurses compared to the traditional obligation-based theories of consequentialism and deontology. I conclude that the virtue-based approach and virtue ethics are plausible moral approaches to the moral complexities that abound in contemporary nursing practice. Moreover, a strong version of virtue ethics that provides adequate action guidance for nurses is a viable possibility.

# REFERENCES AND ENDNOTES

[1] A 'good' death in terms of delivering 'high' quality nursing care might be one that is dignified, that is, pain free, one's emotional and spiritual needs met, and practical matters organized.

[2] R. Hursthouse, *On Virtue Ethics* (Oxford: Oxford University Press, 1999).

[3] This claim is supported in several empirical studies including: A., E. Armstrong, S. Parsons & P., J. Barker, "An inquiry into moral virtues, especially compassion, in psychiatric nurses: findings from a Delphi study", *Journal of Psychiatric and Mental Health Nursing,* 2000, **7,** 297-306. It is also a claim put forward by nurses in teaching and learning sessions in response to the question, 'how do you make moral decisions in nursing?'

[4] Hursthouse, *On Virtue Ethics* 1999.

[5] T., L. Beauchamp & J., F. Childress, *Principles of Biomedical Ethics* 5th ed. (New York: Oxford University Press, 2001).

[6] For example: L. Blum, *Friendship, Altruism and Morality* (London: Routledge & Kegan Paul, 1980); P. Nortvedt, "Sensitive judgment: an inquiry into the foundations of nursing ethics", *Nursing Ethics*, 1998, **5** (5), pp. 385-392.

[7] K. Lutzen & C. Nordin, "Structuring moral meaning in psychiatric nursing", *Scandinavian Journal of Caring Sciences*, 1993, **7**, pp. 175-180.

[8] Lutzen & Nordin, "Structuring moral meaning in psychiatric nursing", p. 176.

[9] Lutzen & Nordin, "Structuring moral meaning in psychiatric nursing", p. 177.

[10] Lutzen & Nordin, "Structuring moral meaning in psychiatric nursing", p. 178.

[11] Ibid.

[12] Ibid.

[13] For example: Beauchamp & Childress, *Principles of Biomedical Ethics*, 2001; S., D. Edwards, *Nursing Ethics – A Principle Based Approach* (Basingstoke: Macmillan, 1996); R. Gillon, *Philosophical Medical Ethics* (Chichester: John Wiley & Sons, 1986).

[14] Lutzen & Nordin, "Structuring moral meaning in psychiatric nursing", p. 179.

[15] K. Lutzen & C. Nordin, "Modifying autonomy – a concept grounded in nurses' experiences of moral decision making in psychiatric practice", *Journal of Medical Ethics*, 1994, **20**, pp. 101-107.

[16] This claim is supported in: Armstrong, Parsons & Barker, "An inquiry into moral virtues, especially compassion, in psychiatric nurses: findings from a Delphi study", 2000.

[17] For example: L. Cohen, "Power and change in health care: challenge for nursing", *Journal of Nurse Education*, 1992, **31**, pp. 113-116.

[18] If I attempt to put myself into another person's shoes and think what it must be like from his perspective, one of the problems is that I take my value and belief system with me. Therefore I cannot see things from this other person's perspective because I am unaware – have no knowledge of – his values and beliefs. See: S., Z. Jaeger, "Teaching health care ethics: the importance of moral sensitivity for moral reasoning", *Nursing Philosophy*, 2001, **2**, pp. 131-143.

[19] By this I simply mean that there are pragmatic reasons that can prevent nurses from asking these sorts of questions and gathering such information. For example, too many nursing activities, too few suitably skilled nurses and insufficient time to deliver the planned nursing care means that nurses do not have a lot of time to spend with patients in order to ask these sorts of questions. Furthermore, the range of needs and interests (ignoring desires) that patients can have is broad. These are not simple notions and again require time to identify and accrue knowledge of.

[20] On the complex multidimensional notions of empathy and sympathy, see: T. Yegdich, "On the phenomenology of empathy in nursing: empathy or sympathy?", *Journal of Advanced Nursing*, 1999, **30** (1), pp. 83-93; L. Baillie, "A phenomenological study of the nature of empathy", *Journal of Advanced Nursing*, 1996, **24**, pp. 1300-1308.

[21] J. Oakley, *Morality and the Emotions* (London: Routledge, 1992).

[22] P., A. Scott, "Emotion, moral perception and nursing practice", *Nursing Philosophy*, 2000, **1**, pp. 123-133.

[23] Scott, "Emotion, moral perception and nursing practice", p. 126-127.

[24] I. Murdoch, *Sovereignty of Good* (London: Routledge & Kegan Paul, 1970).

[25] E., S. Kinion, N., L. Jonke, and N. Paradise, "Descriptive ethics and neuroleptic drug reduction", *Perspectives in Psychiatric Care,* 1995, **31** (2): 11-14, p. 81.

[26] L. Blum, "Compassion" in *Explaining emotions* ed. A., O. Rorty (Los Angeles: University of California Press, 1980), pp. 507-517, p. 513.

[27] Armstrong, Parsons & Barker, "An inquiry into moral virtues, especially compassion, in psychiatric nurses: findings from a Delphi study", 2000.

[28] Benevolence is often called kindness and Hursthouse calls it by its perhaps more old fashioned name, charity. Kindness is clearly part of the compassionate nurses' motives. Lutzen and Nordin claim that benevolence could be seen as a moral virtue (I believe it is). In a grounded theory study, benevolence, the wish to do good, "appeared as the nurses' genuine intentions verbally expressed, to do that which is judged to be 'good' for the 'other'". See: K. Lutzen and C. Nordin, "Benevolence, a central moral concept derived from a grounded theory study of nursing decision making in psychiatric settings", *Journal of Advanced Nursing* ,1993, **18**, 1106-1111, 1107.

[29] E., D. Pellegrino & D., C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), p. 80.

[30] Armstrong, Parsons & Barker, "An inquiry into moral virtues, especially compassion, in psychiatric nurses: findings from a Delphi study", pp. 297-306.

[31] K. Lutzen & A. Barbosa da Silva, "The Role of Virtue Ethics in Psychiatric Nursing, *Nursing Ethics,* 1996, **3** (3), 202-211, p. 203.

[32] Lutzen & Barbosa da Silva, "The Role of Virtue Ethics in Psychiatric Nursing, p. 203.

[33] M. Naussbaum, "Compassion: The basic social emotion", *Social Philosophy and Policy Foundation* ,1996, **13**, 27-58, p. 37.

[34] von Dietze & Orb, "Compassionate care: a moral dimension of nursing", *Nursing Inquiry*, p. 168.

[35] H., J. Nouwen, D., P. McNeill & D., A. Morrison, *Compassion: A reflection on the Christian life* (London: Darton, Longman and Todd, 1982), p. 4.

[36] In nursing, this view is shared by among others: A., G. Tuckett, "An ethic of the fitting: A conceptual framework for nursing practice", *Nursing Inquiry*,1998, **5**, 220-227, p. 221.

[37] This is described by Eisenberg and Miller as when an agent deliberately and intentionally helps and supports another agent, without expecting any reward or punishment, in other words the agent puts the interests of the other ahead of his own for virtuous reasons. See: N. Eisenberg and P. Miller, "Empathy, sympathy and alrtuism: empirical and conceptual" in *Empathy and its Development* eds. N. Eisenberg and J. Strayer (Cambridge: Cambridge University Press, 1987), pp. 292-316, p. 87.

[38] von Dietze & Orb, "Compassionate care: a moral dimension of nursing", p. 174.

[39] This is discussed in: V. Tschudin, *Ethics in Nursing – the Caring Relationship* 3rd ed. (Oxford: Butterworth Heinemann, 2003), pp. 1-17.

[40] Armstrong, Parsons & Barker, "An inquiry into moral virtues, especially compassion, in psychiatric nurses: findings from a Delphi study", pp. 297-306.

[41] For the view that caring is a central virtue in nursing see: J., K. Brody, "Virtue ethics, caring, and nursing", *Scholarly Inquiry for Nursing Practice* 1988, **2** (2), 87-96.

[42] For example: H. Breen, "The Psychiatric nurse – Patient advocate?" *Canadian Journal of Psychiatric Nursing* 1992, **31** (4), pp. 9-11; G., W. Martin, "Ritual action and its effect on the role of the nurse as advocate", *Journal of Advanced Nursing* 1998, **27** (1), pp. 189-194; M. Mallick, "Advocacy in nursing – a review of the literature", *Journal of Advanced Nursing* 1997, **25** (1), pp. 130-138.

[43] Penn thinks that patient advocacy is particularly relevant when caring for patients with palliative care needs, see: K. Penn, Patient advocacy in palliative care. *British Journal of Nursing*, 1994, **3**, 1, pp. 40-42.

[44] P., T. Geach, *The Virtues* (Cambridge: Cambridge University Press, 1977), pp. 150-170.

[45] Reasons for being an advocate include that it is seen as a traditional role of a nurse, nurses know patients better than others health care professionals and nurses have sufficient knowledge to promote the patient's interests. Reasons against include

the idea that being an advocate can be a risky business and that nurses lack sufficient control and power to be effective advocates. See: J. Hewitt, "A critical review of the arguments debating the role of the nurse advocate", *Journal of Advanced Nursing* 2002, **37** (5), pp. 439-445.

[46] P., A. Cooksley, "Caring for the Older Person with a Disorder of the Nervous System" in *Watson's Medical and Surgical Nursing and Related Physiology* 4th ed. eds. J. Royal & M. Walsh (London: Balliere Tindall, 1992), pp. 681-762, pp. 751-753.

[47] Nursing and Midwifery Council, *Code of Professional Conduct* (London: NMC, 2002).

[48] No author credited - "Sinemet" in *Monthly Index of Medical Specialities* ed. C. Duncan (London: Haymarket Publishing Services, 2003), p. 112.

[49] Downing asserts that the assessment of pain is complex. It needs to be carried out over a period of time to build up a realistic and accurate picture of the pain, its effects on the patient and the efficiency of pain management strategies. The emphasis is therefore upon a nurse who needs to be motivated to ask relevant questions, spend time with the patient, return again and again and repeat the questions, review the patient's lived experience of the pain, spend time documenting this information in the nursing records and liase with other members of the health care team. The major objective is to work together to alleviate the pain, facilitate coping strategies and promote the independence of the patient. See: J. Downing, Palliative care pain. *Nursing Times*, 1997, **93**, 34, pp. 57-60.

[50] No author credited - "Morphine" in *Monthly Index of Medical Specialities* ed. C. Duncan (London: Haymarket Publishing Services, 2003), p. 121.

[51] S. Ahmedzai & D. Brooks, "Transdermal fentanyl versus slow release oral morphine in cancer pain: preference, efficacy, and quality of life", *Journal of Pain & Symptom Management*, 1997, **13**, 5, pp. 254-261.

[52] A., E. Armstrong, S. Parsons & P., J. Barker, "An inquiry into moral virtues, especially compassion, in psychiatric nursing: findings from a Delphi study" *Journal of Psychiatric and Mental Health Nursing,* 2000, **7**, pp. 297-306.

[53] Hursthouse, *On Virtue Ethics* 1999.

[54] Ibid.

[55] For example: A. Kenny, *Action, Emotion and Will* (London: Routledge, 1963); N. Rescher, *Rationality: A Philosophical Inquiry into the Nature and the Rationale of Reason* (Oxford: Oxford University Press, 1988).

[56] R. Hursthouse, "Virtue theory and abortion" in *Virtue Ethics* eds. R Crisp & M. Slote (Oxford: Oxford University Press, 1997), pp. 217-238.

[57] Hursthouse, "Virtue theory and abortion" in *Virtue Ethics,* p. 227.

[58] Aristotle, *The Nicomachean Ethics*, trans. D. Ross, revised J., L. Ackrill and J., O. Urmson (Oxford: Oxford University Press, 1980).

[59] M. Slote, *From Morality to Virtue* (New York: Oxford University Press, 1992); M. Slote, "Agent-Based Virtue Ethics" in *Virtue Ethics* eds. R. Crisp & M. Slote (Oxford:

Oxford University Press, 1997); M. Slote, *Morals with Motives* (Oxford: Oxford University Press, 2001).

[60] R. Hursthouse, *On Virtue Ethics* (Oxford: Oxford University Press, 1999).

[61] S. Parsons, P., J. Barker & A., E. Armstrong, "The teaching of health care ethics to students of nursing in the UK: a pilot study", *Nursing Ethics*, 2001, **8** (1), pp. 45-56.

[62] Hursthouse, *On Virtue Ethics* 1999.

[63] P. Benn, *Ethics* (London: UCL, 1998).

[64] R. Norman, "Aristotle: the rationality of the emotions" in *The Moral Philosophers* (Oxford: Clarendon Press, 1983), pp. 37-55.

[65] This example can be seen as an illustration of 'benevolent deception', the withholding of a piece of information for morally good – benevolent – motives. Since benevolence is a virtue, there will be times when this sort of practice is an example of acting well. Clearly from the virtue-based perspective, there are differences between blatant lying, deception and withholding information. If a nurse lies to a patient without morally good (virtuous) reasons and without the patient even asking a question, then this will be an example of acting badly. As just noted, this is not the same as withholding information. Deceiving a patient sometimes includes an element of withholding information, for example, when the relatives of a patient state that under no circumstances should the patient be told about their diagnosis, because they believe that he just wouldn't cope with the news. This might then set in motion a series of deceitful actions, for example, nurses who begin to avoid the patient's questions. These sorts of situations are on a practical and moral level undesirable. Morally speaking, the vice of dishonesty is being exercised thus at least some of these are examples of acting badly. The relative's motives appear morally good, but no assumptions should be made regarding the sincerity of such motives.

[66] For example: Benn, *Ethics*, 1998; J. Rachels, *The Elements of Moral Philosophy* 3rd ed. (New York: McGraw Hill, 1999); R., B., Louden, "On Some Vices of Virtue Ethics" in *Virtue Ethics* eds. R. Crisp & M. Slote (Oxford: Oxford University Press, 1997), pp. 201-216; P. Pettit, "The Consequentialist Perspective" in *Three Methods of Ethics* (Oxford: Blackwells, 1997), pp. 92-174.

[67] This is Hursthouse's interpretation in *On Virtue Ethics,* 1999.

# CHAPTER 8 – MACINTYRE'S ACCOUNT OF THE VIRTUES[1]

## Introduction

### Summary of the argument so far

I have argued that the virtue-based approach and a strong virtue ethics are plausible and attractive moral approaches for use in contemporary nursing practice. The need for such an approach stems from the vulnerability, powerlessness and fear experienced by patients with illness. In order to help patients survive and recover from illness, nurses ought to develop and sustain a virtue-based helping relationship. Important virtues include compassion, courage, respectfulness, justice and patience. Moreover, the emphasis is not purely on actions and their consequences. Rather the emotions of both patients and nurses are realized and accounted for. In part because of the innumerable complex moral tensions in nursing practice, it is important to the ends of the virtue-based approach that nurses utilize judgment and moral wisdom in their moral decision-making. Moral decision-making in accordance with the virtue-based approach is context-dependent, relational and particularist.

I believe that the above account is plausible and well grounded. However, in the work of MacIntyre, there is a contemporary moral philosopher whose ideas about the virtues provide further philosophical foundation for the virtue-based approach to contemporary nursing. Therefore, in this Chapter I examine MacIntyre's work and in the next Chapter, I relate some of his themes to my account of the virtue-based approach.

### MacIntyre's account of the virtues

MacIntyre is dissatisfied with and pessimistic about many of the claims inherent in modernism. The objects of his disapproval include some of the claims made by contemporary political philosophy, especially liberalism, and modern moral philosophy,

particularly what he calls the 'Enlightenment project'. What does MacIntyre propose as an alternative moral theory?[2] In brief, he responds by proposing a neo-Aristotelian ethics that is (a) teleological, (b) socially contextualized and (c) historicized. According to MacIntyre, three features are not found in contemporary obligation-based moral theories. Or if these features are present, then they are neglected and given low priority.

I shall examine MacIntyre's concerns with contemporary ethics in more detail, as this provides the philosophical background and motivation for his theory. Next, I shall present the three major theses, presented and defended in *After Virtue*, that constitute his account of the virtues. I end this Chapter by considering some of the objections and merits of his theory.

**MacIntyre on modern moral philosophy**

MacIntyre's dismissive claims about modern moral philosophy are similar in some respects to the rejection of Kantianism and utilitarianism – the moral theories that dominate contemporary moral philosophy – that Anscombe[3] made in 1958. While Anscombe's thesis was grounded in the lack in contemporary society of a theistic deity, one can still see in her writings the seeds of at least the core of MacIntyre's ideas. (Indeed Anscombe has influenced many philosophers who might be labelled as anti-theorists, besides MacIntyre, another example is Williams.[4])

Prior to *After Virtue*, MacIntyre began to demonstrate his disagreement and dislike of much of the substance of modern moral philosophy.[5] In short he criticized these moral theories and the theorists who proposed the theories, because they failed to socially and historically contextualize these theories; they tended to ignore the role and importance of history and social theory in moral philosophy. The result was that the development of moral theories and moral persons over time, place and culture is

ignored. Furthermore, the historical context of the philosophers advancing such theories and ideas is also neglected.

In *After* Virtue, MacIntyre continues to develop the above claims. Additionally, MacIntyre is disgruntled with modern moral philosophy, because it is predominantly concerned with trying to settle what appear to be intractable moral disagreements, concerned with what are frequently irresolvable dilemmas. One reason that such dilemmas are irresolvable is that conflicting moral positions invoke incommensurable premises, for example, the ethics of abortion invokes moral (and legal) rights and the Kantian idea of universalizability. The meanings now given to these (and other) moral notions are hidden, disjointed or empty of substance, that is, meaningless. This is principally because the meaning of these moral notions originally derives from historical contexts much different from contemporary modernism.

One of MacIntyre's main claims is that some of the social and political arrangements typical of modernity prove hostile to the cultivation and exercise of the virtues. MacIntyre argues that the virtues can only flourish if one has an adequate, shared idea of what the good life for man is. For MacIntyre, modernism ignores this Aristotelian concept.

MacIntyre argues that in contemporary western cultures, virtue terms such as 'justice' and 'desert' are used out of context. These terms have been redefined to refer to one's obligation to obey the moral rules or principles of justice. MacIntyre argues that this flawed view of the virtues is adopted by modernism, especially contemporary liberalism. Consequently liberalism fails to develop a shared view of the virtues. Moreover, because liberalism is wrought up in the idea of the capitalist market, the vices, such as individualism and acquisitiveness, are instead cultivated. Finally, liberalism, more specifically liberal theory, is also committed to an impartial and neutral

view of the good. It maintains an unbiased view between competing conceptions of the good. One result of this is that the virtues, especially justice, honesty, and courage are not cultivated.

Since 1981 MacIntyre has published four major works in moral and political philosophy: *After Virtue* in 1981 (2nd edition published in 1985); *Whose Justice? Which Rationality?* in 1988; *Three Rival Versions of Moral Enquiry* in 1990; and most recently in 1998, *Dependent Rational Animals - Why Human Beings Need the Virtues.* Taken together, plus other published papers, MacIntyre develops an original set of theses, which he argues provides a convincing account of the moral and political life.

**MacIntyre's Argument**

In this section, I describe MacIntyre's argument, although I limit this discussion to the MacIntyre found in *After Virtue*. In his later writings, he revised some of his earlier claims. If appropriate I cite from the relevant literature. Where the argument is important and dense, I quote MacIntyre at some length.

I limit this discussion to the 3 major theses presented in chapters 14 and 15 in *After Virtue*, where MacIntyre develops his account of the virtues. I shall present the 3 theses (T1-T3) under the following headings (MacIntyre does not adopt these headings). I then describe and where necessary explain each one:

- T1 – The role and importance of MacIntyre's narrative conception of the self in morality;
- T2 – MacIntyre on practices, goods and the virtues;
- T3 – The role and importance of a tradition of enquiry in morality.

**T1 - The role and importance of MacIntyre's narrative conception of the self in morality**

MacIntyre objects to the conception of the 'self' advanced by contemporary liberalism, which views individuals as essentially deciding and choosing beings. He rejects the liberal view that choosing and deciding largely determine the moral worth and value ascribed to an act or person. The liberal self understands the good only as one part of making choices and decisions; and this self is the sole arbiter of the latter processes. This conception of the self can say, for example, 'I am what I decide to be' or 'I shall choose x over y'; it can, if it so desires, include or ignore any or all of the contingent social features of one's existence.

Against this conception of the self, MacIntyre proposes a narrative conception. In *After Virtue* MacIntyre writes,

> man is in his actions and practice, as well as in his fictions, essentially a story-telling animal. He is not essentially, but becomes through his history, a teller of stories that aspire to truth. But the key question for men is not about their own authorship; I can only answer the question 'What am I to do?' if I can answer the prior question 'of what story or stories do I find myself a part?' We enter human society, that is, with one or more imputed characters – roles into which we have been drafted – and we have to learn what they are in order to be able to understand how others respond to us and how our responses to them are apt to be construed.[6]

It is clear that MacIntyre rejects the liberal idea that an individual is principally a decider and chooser. According to MacIntyre, a person has an identity, which is partly conceived before he or she makes any decisions or choices. Therefore, the central question in persons' moral lives is not concerned, as liberals and obligation-based theorists claim, with decisions and choices, which we ought to make, "but rather [it is] a question about how we are to understand who we are".[7]

To summarize these 2 different conceptions of the self: liberalism places the emphasis on the idea that humans are primarily choosing and deciding beings. In contrast,

MacIntyre's narrative conception focuses on the moral context, history and background circumstances, which are unchosen, but which help to inform and make ones choices meaningful and comprehensible.

Why does MacIntyre refer to his view as 'narrative'? Clearly, this relates to his claims about man as a story-telling creature. Furthermore, Horton and Mendus think that MacIntyre's conception of the self is called narrative because,

> it implies that answers to questions about what we ought to do involve not merely (or primarily) choosing what to do as individuals, but also, and essentially, discovering who we are in relation to others.[8]

It can be seen that an important theme is developing: it is crucial that one reflects on and comprehends how one responds to others and how others respond to us.

This thesis about the narrative conception of the self in MacIntyre's moral theory contains both epistemological and normative dimensions. Broadly, for individuals to be properly understood – for one to fully understand oneself – reference to the wider community, to other beings, needs to take place. There is a requirement to understand that through social relations and interpersonal responses, one's being is partly constituted. The normative dimension follows from these epistemological claims, for these claims have implications for how humans ought to live. This relationship – between the epistemological and normative – is philosophically interesting and stimulating. It is, however, problematic as some critics argue that the normative dimension does not necessarily follow from the epistemological (I discuss this point further in the 'Objections' section).

What ought I to do? This question, one of the pivotal questions in moral philosophy, lies at the core of obligation-based ethics. MacIntyre argues that one must acknowledge the importance of the narrative structure to one's life; the story of my life

has a certain narrative structure "in which what I am now is continuous with what I was in the past".[9] Rather than one's life being merely or principally a set of choices and decisions, it is a *search*, a search for one's own identity; for who or what I am and for what I ought to do. MacIntyre calls this search a *quest* and it is essential to what he calls 'the unity of a person's life'. On this, he says

> In what does the unity of an individual life consist? The answer is that its unity is the unity of a narrative embodied in a single life. To ask, 'What is the good for me?' is to ask how best I might live out that unity and bring it to completion. To ask, 'What is the good for man?' is to ask what all answers to the former question must have in common. But now it is important to emphasize that it is the systematic asking of these two questions and the attempt to answer them in deed as well as in word which provides the moral life with its unity. The unity of a human life is the unity of a narrative quest.[10]

The most important part of discovering the unity of one's life is asking the questions 'what is the good for me?' and 'what is the good for man?' The unity of one's life is, in part, achieved by aiming to provide responses to these two questions, in both one's actions and dialogue. It should be noted, however, that this unity to which MacIntyre refers must be understood from within a social context. Without this perspective, there can be no substance to a person's life (however, remember that according to MacIntyre, one cannot choose one's social context).

**T2 – MacIntyre on practices, goods and the virtues**

MacIntyre objects to the lack of teleology within contemporary liberalism, indeed the latter denies the possibility of a telos for man. One result of this is liberalism's inability to evaluate what and who we are and compare and contrast this with what and who we ought to be. In short, MacIntyre proposes a moral theory that has the virtues at its core.

MacIntyre accords social context a prominent role in morality. Further, he thinks it is crucial for humans to consider how their present identity has been formed from the

past; MacIntyre refers to this as the 'given' in our lives. These ideas are also present in his concept of a practice. MacIntyre writes,

> By a 'practice' I am going to mean any coherent and complex form of socially established co-operative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended.[11]

Examples of practices given by MacIntyre include chess, football, farming, architecture, music, painting and the enquiries of physics, chemistry, biology and history. One of the most important points about practices, for moral philosophy at least, is that there are standards of excellence internal to each practice. On this, Horton and Mendus write

> For example, in order to play chess well, a player must heed the standards which define the playing of chess. Not just anything counts as playing chess well, and the features which do count are ones which are defined by the practice. They are not matters for individual preference or decision-making.[12]

For MacIntyre, morality in general and the virtues in particular should be viewed as practice-based. Indeed, he claims that the concept of a practice is crucial to an adequate and satisfactory account of the virtues. Individuals cannot simply decide and choose what acting morally well means to them. Instead acting well is to be determined according to the type of practice(s) one is engaged in. One can see that instead of rigid moral rules and obligations, it is the virtues that have a central position in MacIntyre's conception of morality. He argues that morality should be conceived as a life that embodies the virtues. One's understanding of why particular character traits count as virtues, and indeed on the question of what virtues are, depend upon our ability to (a) recognise the role that virtues play in practices and to (b) reflect critically on the central role played by the virtues in the narrative unity of the self.

In chapter 14 in *After Virtue* entitled "The Nature of the Virtues", MacIntyre provides a tentative definition of a virtue. He writes

> A virtue is an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods.[13]

MacIntyre holds that only social and political arrangements that sustain the practices and ensure the supply of the internal goods exclusive to each practice, are justifiable.

Before I provide MacIntyre's later revised formulation of a virtue, the idea of internal goods requires some clarification. An obvious question perhaps, but are there external goods? The response to this is affirmative. MacIntyre uses the game of chess to explain the distinction between these two types of goods (however, other practices could also be used to illustrate this distinction). It is possible to gain both internal and external goods by playing chess. Examples of external goods include money, status and prestige. These goods can be achieved in other ways besides playing chess; they are only externally and contingently attached to the playing of chess. MacIntyre asserts that the achievement of external goods "is never to be had *only* by engaging in some particular kind of practice".[14]

Conversely, the goods internal to playing chess – the practice of chess – cannot be achieved by any other means but by playing chess, or as MacIntyre adds, another game of that kind. What might the internal goods of chess be? It is difficult to state categorically what these might be. However, internal goods could include the sorts of feelings and attitudes developed and sustained in those who play chess and take pride in aiming to be excellent at playing chess. These goods are achieved through striving for excellence, meaning that individuals aim to improve on previous practitioners whose participation in the practice has formed the history and standards of the practice. Why does MacIntyre call these goods internal? Two reasons are given:

> first, as I have already suggested, because we can only specify them in terms of chess or some other game of that specific kind and by means of examples from such games...and secondly because they can only be identified and recognized by the experience of participating in the practice in question.[15]

In reply to the question, 'what are the internal goods of chess?' it is impossible for one who does not play the game of chess to answer. For MacIntyre, individuals ought to relate their lives to the numerous different types of practices that make up their lives and the virtues are crucial to this process. His reformulated definition of a virtue, which takes this into account, suggests virtues are to be understood as dispositions

> which will not only sustain practices and enable us to achieve the goods internal to practices, but which will also sustain us in the relevant kind of quest for the good, by enabling us to overcome the harms, dangers, temptations and distractions which we encounter, and which will furnish us with increasing self-knowledge and increasing knowledge of the good.[16]

It is useful to repeat the 4 claims made in the above quote. The virtues:

I. sustain practices;

II. enable humans to achieve the internal goods of practices;

III. ensure that we continue on our search or quest for the good life;

IV. help to provide us with greater self-knowledge and knowledge of the good life for man.

Thus, the virtues help us to proceed with our search for the good life. They help us to prevent or deal with harmful and negative aspects of life, which might lead us away from the quest for the good. Furthermore, the virtues develop one's knowledge of oneself and knowledge of what the good for one consists in.

Before I consider MacIntyre's concept of a tradition, I shall comment further on what MacIntyre means by a good life. As noted in Chapter 3, many virtues are necessary to meet the ends of practices that humans participate in. For example, the virtues

required to achieve the ends of law will differ from those needed in farming. Furthermore, virtues are needed to sustain different types of communities, for instance, political and social communities; respective examples here are different political ideologies and families. Men and women can search for the good in their moral lives, while philosophers too can enquire about the nature of the good. MacIntyre concludes, albeit provisionally, that the good life for man is,

> the life spent in seeking for the good life for man, and the virtues necessary for the seeking are those which will enable us to understand what more and less the good life for man is.[17]

However, the view that the good life is the life spent *seeking* the good life is open to criticism (this is discussed in the 'Objections' section). For MacIntyre, the practices and the exercise of the virtues that sustain the practices must knit together in such a way that individuals come to understand that the life of virtue is indeed a good way of living one's life.[18] After all, it should not be assumed that individuals will *know* that the virtuous life is worthwhile, more so than say an egoistical life. But the question of how one can know that the life of virtue is a good life and how different practices *knit* together are complex.

**T3 – The role and importance of a tradition of enquiry in morality**

To recap thus far: First, MacIntyre has provided a narrative conception of the self, which has advantages over liberalism's conception, such as it takes seriously the moral context, history and background circumstances of individuals' lives. Second, MacIntyre defined the virtues in relation to practices and then linked this to the good life for man.

The third (and final) stage concerns the concept of a tradition of enquiry. According to MacIntyre, it is important to remember that contemporary liberalism ignores the role

and importance played by social context and history in morality. One result of this is that the given in one's moral life is not acknowledged by liberalism.

MacIntyre argues that individuals cannot search for the good for man or exercise the virtues *qua* individuals. He provides two reasons for this claim. First, individuals live in different social circumstances, living the good life changes according to these circumstances. For instance, the good life for a sixth-century Athenian general will be quite different to the good life for a seventeenth-century farmer. Or the good life for a homeless person will be markedly different to that of a millionaire businessperson. Second, all individuals have a particular social identity, with which one approaches one's specific circumstances. For example, I am someone's son, my sister is someone's daughter, I am a member of the nursing profession and a citizen of England. MacIntyre believes that what is good for me *must* be the good for others who take on these roles. Furthermore, Macintyre writes

> I inherit from the past of my family, my city, my tribe, my nation, a variety of debts, inheritances, rightful expectations and obligations. These constitute the given of my life, my moral starting point. This is in part what gives my life its own moral particularity.[19]

This reference to debts, inheritances, rightful expectations and obligations helps to shed some light on one's understanding of MacIntyre's phrase, the 'given in our lives'. These features of the moral life are inherited – consciously or not – from the past. MacIntyre seems to be suggesting that these features will ensure particular moral starting points. While this implies (at least on the surface) individualism at odds with his previous claims (especially those in T1), it is balanced by his view that part of one's identity consists in social and historical roles. These roles consist in ends that apply to each person who takes on that role. It seems to me that MacIntyre is no liberal when, regarding the narrative conception of the self, he says "the story of my life is always embedded in the story of those communities from which I derive my identity".[20] In other

words: 'I cannot map my identity, I am unable to keep track of who and what I am, without reference to other beings, who form the community I live in'.

On MacIntyre's view, much of what I am is inherited. Parts of the past impinge on my present. I am part of a history, although I may not realise or accept this. As such, I am a bearer of a tradition of enquiry. In *After Virtue* MacIntyre defines a living tradition as,

> An historically extended, socially embodied argument, and an argument precisely in part about the goods which constitute that tradition.[21]

Greater clarification on this definition is given by Mulhall and Swift who write

> A tradition is constituted by a set of practices and is a mode of understanding their importance and worth; it is the medium by which such practices are shaped and transmitted across generations.[22]

Mulhall and Swift state that there are many types of traditions. Three examples are moral, for instance, humanism, religious, for instance, Catholicism, and economic, for instance, a profession. It is important to note that traditions are not static, but dynamic. Possibilities exist not only for an individual to embark on a quest and to acknowledge the given in one's life, but also to reflect in a critical manner about the nature and content of the traditions and practices which one finds oneself a part. This dynamism is described by Horton and Mendus, who remark,

> Traditions change and develop over time; some decay and fall into terminal disrepair and some emerge in response to changed circumstances.[23]

Because of this dynamism, MacIntyre believes that the concept of a tradition is not in the least conservative (however, it is clear later on that others disagree on this).

MacIntyre's moral theory can now be understood to encompass a narrative conception of the self, a conception of practices and the crucial role of the virtues in the

sustenance of the practices and latterly, an understanding of a tradition of enquiry, which situates the aforementioned in a wider context.

As noted earlier, the diverse sets of practices that exist within society define the virtues. These practices are situated within and help to sustain a tradition of enquiry, "which provides the resources with which the individual may pursue his or her quest for the good".[24] Included, as a vital component of this quest is moral deliberation and action. These rely heavily on standards of rationality, which form part of the overall tradition of enquiry in question. Since *After Virtue*, MacIntyre has increasingly focused on the notion of rationality and the concept of a tradition.

**Further discussion of and objections to MacIntyre's thesis**

In this section I discuss further some of the detail in MacIntyre's moral argument as outlined in *After Virtue*. I present several objections levelled against his theory. These points of discussion and objections are crudely categorised according to the thesis that the objection targets. But these theses merge together and overlap. It is therefore necessary and fruitful to remember that each one forms part of a larger moral argument and each needs to be comprehended and contextualised as such. Below is T1-T3 again:

- T1 – The role and importance of MacIntyre's narrative conception of the self in morality;
- T2 – MacIntyre on practices, goods and the virtues;
- T3 – The role and importance of a tradition of enquiry in morality.

**T1 – The role and importance of MacIntyre's narrative conception of the self in morality**

**On the epistemological and normative dimensions of the self**

MacIntyre alludes to the fact that his narrative conception of the self contains both epistemological and normative dimensions. As noted, Horton and Mendus pick up on

this. Consider the following example. John is a 40-year-old farmer, married to Jean. They have 2 children, one son, Daniel aged 10 and a daughter, Julie aged 5. John has farmed all his life, inheriting his North Yorkshire farm from his parents 10 years ago. He employs two aides, Brian and Todd. There are other farms in the surrounding area, the most prominent one is owned by John's friend Jack. For John to get to know himself well, for him to strive to understand who and what he is, he needs to be aware and understand that his being is partly constituted through his relations with and responses to others. These others include John's relationships with Jean, Daniel and Julie. Additionally, there are his relationships with Brian and Todd to consider and how he gets on and responds to Jack, other local farmers and the local community. These claims are epistemological in nature, because they deal with beliefs about one's identify (in this sense then, these claims also have a metaphysical component). Horton and Mendus claim that the normative dimension –how one should live one's life - follows from these epistemological claims. In other words, knowing who one is and what kind of person one is and relating this knowledge to getting on with others, has implications for how one ought to live.

The above epistemological and normative claims appear plausible. It is clear that these claims apply to general ethics as a whole and not just to virtue ethics. An individual who fails to understand or does not attempt to understand herself, one who takes little or no interest in how she responds to others (or how others respond to her) could be called egoistic, self-interested or even, in an extreme case, amoral. If everyone acted in self-interested ways, then social relations would crumble or fail to develop in the first place. Because of their lack of concern for others, individuals would show no interest in inculcating the virtues; so that for example, trust, honesty and loyalty would be marginalized. The lack of such virtues would not merely be responsible for the failure of human relationships; business and economics would also suffer badly. As someone who wants to be virtuous, it is important that when I reflect on my thoughts and plan my

actions (at least those I am capable of planning), I take others' interests into account. I would add that I ought to care about others' interests. Suppose that Ethel has just started work as a typist in my small company. I know that one of my positive traits is showing patience with others. This trait did not come naturally; I had to work hard to inculcate it. But I saw how being patient helped other people and so I aim to be patient with others. Nancy, the senior typist, complains to me that Ethel is 'just too slow'. Nancy believes that Ethel should have a typing speed in excess of 35 w.p.m. I talk with Ethel and during the conversation it emerges that Ethel, though experienced, is a very nervous person who needs a few weeks to settle into a new post. I tell Ethel that we can wait for her to settle in. I ask Ethel if I can discuss this with Nancy. After gaining her permission, I explain the situation to Nancy and ask that she is more patient with Ethel. Two weeks later, Ethel has settled into her new job and has made a few friends. She now types at 60 w.p.m. This example illustrates the moral value and worth of knowing one's traits (positive and negative), caring about others and whenever possible helping others. It seems to me that epistemological and normative claims and the necessary link between them, forms the basis of morality; at least if one wishes to be moral and values forming good relationships with others.

#### On choosing and deciding

If one accepts MacIntyre's primary claim, that contemporary liberalism views individuals as *essentially* choosing and deciding beings, then the secondary claim, that the process of deciding and choosing determines the moral worth of a person or a person's acts, remains open to criticism. There is more to this than *merely* choosing and deciding. Many liberals are deontologists who focus on obeying moral obligations, for example, beneficence, justice and respect for one's autonomy. Other liberals are consequentialists, concerned with maximizing or optimizing good consequences. As noted in Chapter 4, deontologists and consequentialists focus on actions especially the question 'what should I do?' Their response is to invoke moral obligations, rules and

principles. Deontologists also invoke the notion of moral rights. The latter theorists are convinced that the moral value of an act concerns not only the aforementioned moral notions, but also moral concepts such as intention. I accept that one needs to choose which of the aforementioned moral notions will guide one's actions. But I have noted that morality is also concerned with other relevant features. And although exercising judgment involves a series of choices and decisions, this moral concept and moral wisdom too require extensive examination.

MacIntyre is caustic and sceptical at the prime role liberals assign to choosing and deciding. An example showing that MacIntyre is anti-liberal is his claim that one is 'drafted' into human roles, which provides one with one's character. His use of 'drafted' implies one has no choice. This supports the idea that in wanting a moral theory that takes into account the role of history and society in moral philosophy, MacIntyre has unfortunately gone overboard in his criticism of the idea of 'choosing and deciding'. His theory has undoubted merits (see 'Merits' section). However, it is severely anti-liberal and it does not need to be, at least not in such a sustained manner.

**On the good life**

According to MacIntyre, men and women can search for the good in their moral lives. For him, it is *searching* for the good life that actually constitutes a good life. Two points here are worth making. First, there is no mention of a shared conception of the good. But, if each person can search and discover a good then this is a liberal, not a MacIntyrian, idea. Second, and more importantly, how would MacIntyre respond to the following: 'during one's search for the good life, one displays, on several occasions, certain vices, for instance impatience and intolerance. Is this still an example of a good life?' It is hard to see what MacIntyre's strategy could be here. I doubt he would conclude that this sort of life is a life of vice, because acting from the vices 'on several occasions' does not constitute *a life* of vice. Indeed, it suggests that there were many

times when one did not act out of the vices. MacIntyre claims that the virtues necessary to search for the good life are those that help shed light on what the good life is and is not. These virtues are intellectual virtues (noted by Aristotle in Chapter 3). Wisdom, both theoretical and practical, is an example of an intellectual virtue (moral wisdom has been examined in detail in the previous Chapter). The role of the intellectual virtues such as wisdom is clear to see when one is searching for something. It will be beneficial to the searcher if one possess wisdom rather than say the moral virtue of compassion (however, I suggest that patience is also implicated).

**Denying a telos for man?**

Another example of Macintyre's characterization of liberalism is his implication that it denies a telos for man. Is a telos for man the *only* way in which one can formulate who one ought to be and what one ought to do? If these two claims are correct, then it is true to suggest that liberalism is unable to contrast who one is and what one does with who one ought to be and what one ought to do. A simple, yet accurate, characterization of liberalism holds that each person is a choosing and deciding being. If correct, this then explains why a telos for man (an overall purpose for mankind) is denied by it.

In his defence, MacIntyre does suggest that human choices are important to our 'selves'. However, on his view one is required to take other features into account. For example, moral context, history and background circumstances, because these help us to understand our choices and decisions. I concur with MacIntyre on this; without these features our choices and decisions would effectively be meaningless. On MacIntyre's view, one could conclude that liberals regard choosing and deciding as sufficient in morality. MacIntyre believes however that these processes are only necessary and as such, are only of use when contextualized. However, some liberals would agree with MacIntyre on this. Therefore, MacIntyre has done contemporary liberalism a disservice

by making such a broad and perhaps inaccurate representation of it, particularly the liberal conception of the self.

**Man as a story telling animal**

MacIntyre says that man is *essentially* a story-telling animal. Is this an accurate representation? Especially during childhood, stories and story telling are undeniably an important part of one's moral education. As exemplified by so-called fairy tales, often these stories do not aim at the truth. But they serve a vital role in entertaining and amusing children; moreover they teach children about good and bad people, the world and one's place in it. In adulthood too, stories do not always aim at the truth. For example, some types of stories aim to stretch one's imagination (riddles) or make one laugh (jokes). Others, of course, aim at telling people what and why events occurred in the past (historical stories). The latter is an example of narratives that aim at the truth or at least the historian's version of the truth. Aristotle argued that man is a rational animal: stories play an important role in determining standards of rationality. Of course, much of MacIntyre's claim depends upon what is meant by 'truth'. The philosophical literature describes several theories of truth, for example, coherence[25] and pragmatic[26] theories of truth. It will, in part, depend upon which theory is adopted as to whether the telling of stories is *always* a means of relaying truthful information.

MacIntyre's narrative conception of the self is relevant to moral philosophy. If by 'stories' MacIntyre means, not just fairy tales that adults tell to children, but rather relaying information about one's life to other people, then I would agree that man is *essentially* a story-telling animal.

## T2 – MacIntyre on practices, goods and the virtues

### The flourishing of the virtues in modernity

MacIntyre argues that the virtues cannot flourish within modernity, because radical disagreement exists on the notion of the good life for man. There is therefore no single shared conception. His conclusion is that the virtues will thus be marginalized. On this claim, Mason asks

> Why does it follow that the virtues must suffer when there is no agreement on a substantive conception of the good.[27]

To illustrate MacIntyre's argument, Mason focuses on distributive justice. To summarize MacIntyre here: justice as a virtue was originally conceived in terms of desert. What one deserved was judged according to one's contribution to the community, which held a shared conception of the good. However, as noted earlier, the virtue of justice has become redefined in terms of a disposition to obey the rules and principles of justice. In part, this has happened because of the lack of any consensus regarding what forms the community's good. But because there are different rules and principles of justice, there is radical disagreement on the nature and content of justice as a virtue (if it is viewed as a virtue at all).

Mason is uncertain about what MacIntyre's precise point is. He believes that MacIntyre might be making one of three points:

1. The virtue of justice will be marginalized because it is understood as supplementary to the rules and principles of justice. However, even in this context, Mason claims that justice as a virtue could still thrive. He argues that no necessary reason arises why the status of justice within our culture must diminish; despite the fact that various conceptions of justice as a virtue exist. He concludes that virtue terms – desert, for instance – could remain widely

used in everyday discourse and humans could continue to highly value the virtues;

2. The virtue of justice – understood, according to MacIntyre, as a trait that is needed to sustain a particular practice – will be marginalized. Mason thinks that justice, as a virtue on this conception will include one's ability to impartially judge one's contribution to the community's good. Therefore, if the virtue of justice was understood as a disposition to obey the rules and principles of justice, it might be conceived as a disposition to obey the rule: "people should be rewarded in accordance with their contribution to the community's good".[28] For Mason, this rule is plausible and could attract supporters. Mason is aware that MacIntyre's response might be to argue that this rule would still be insufficient. This is because there would remain no shared conception of the good. Mason believes that this reply would lead MacIntyre into a tautology. Mason writes

> justice, conceived (at least in part) as a disposition to reward people according to what they deserve on the basis of their contribution to the good of the community will not flourish where there is radical disagreement, since part of what it is for it to flourish is for people to share a conception of the community's good and to believe that contributions to it should be rewarded.[29]

3. Finally, MacIntyre might instead be saying that justice, as a virtue needed to sustain practices, cannot flourish unless this conception is widely accepted. This is because if there is no practice-based conception of the virtues, then the shared practices that ground and define the virtues will not survive. This idea links to MacIntyre's claim that individuals are unable to seek the good life or exercise the virtues only *qua* individuals. The point here is that some form of shared understanding about the practices and their internal goods is required to sustain the practice in question. And the follow up claim is that if consensus is present, then a measure of co-operation will be too. This co-operation,

> including the forming and maintenance of good relationships between individuals, assisted by the exercise of the virtues, will help people in their search for the internal goods.

However, Mason counters this argument by suggesting that while it avoids the aforementioned tautology, for the virtues to flourish he believes that there need not be a shared conception of the good and the virtues need not be the same across communities. On the flourishing of the virtues, Mason writes

> the virtues might also flourish in a society made up of a number of different practices, each practice involving a group of individuals who shared a conception of the good, and hence who could co-operate with each other in pursuit of it.[30]

I accept this claim. Justice as a virtue is distinct from justice as a disposition to obey the principle of justice. In part the difference is a matter of moral motivation. That is, the virtue of justice is a character trait that individuals inculcate and exercise on a habitual basis. They do so because they think it is valuable for its own sake and because they understand that being just will help to benefit others. Acting from the obligation of justice is different because one can act in accordance with moral obligations without accepting and understanding what it means to think and feel just. The obligation or principle of justice focuses on just actions and the motive is one of moral and legal duties. However, as long as individuals value the content of justice as a virtue (and other virtues too) and there is a real sense of moral admiration for those who are just, plus a dedicated and consistent attempt to foster the virtues, especially in children, then it seems to me that the virtues can flourish.

Moreover, I agree with Mason on: (a) there need not be a shared conception of the good; (b) the virtues need not be the same across communities; and (c) the virtues can flourish given different types of practices, where within each practice a shared

conception of the good exists. However, MacIntyre suggests several times in *After Virtue* that he might also agree with (c), insofar as he readily accepts that different types of practices exist in society. I doubt whether MacIntyre would insist that there ought to be just one shared conception of the good within all of these practices. Even in (c) above, I would expect some individuals within a specific practice not to agree entirely on the conception of the good. There would probably be some shared items on each person's list. Discussion and debate could centre on which of these items are most plausible and why. Moreover, there need not be any utilitarian calculus performed. Furthermore, complete consensus on the good among many individuals is something that is unrealistic, unwelcome and not worthy of admiration. As Rawls[31] remarks, disagreement over different conceptions of the good is to be expected in a modern democratic society.

MacIntyre responds to these comments by arguing that such disagreements are resolvable, but only by appealing to a form of Thomism, a tradition of moral thought based upon the work of Thomas Aquinas. Crudely, he thinks that his version of Thomism has rationally compelling reasons that will convince others to jettison their own theories and adopt Thomism instead. MacIntyre's version of Thomism explored in *Whose Justice? Which Rationality?*[32] unsurprisingly adopts a fixed conception of the good for man. Consequently this ensures there are no radical disagreements in morality and politics. MacIntyre aims to show in *Whose Justice? Which Rationality?* why other theorists should abandon their traditions of moral thought. He insists that once they understand his version of Thomism, they will indeed do so.

**On practices**

The virtues are not merely required to engage in the practices. Nor are they just required to meet the ends of each practice in a morally (and technically) excellent manner. Instead, the practices *define* what the virtues are. In other words, the

practices tell us which traits are to be counted as virtues and why and provides their content.

#### Miller on MacIntyre's notion of a practice

Miller[33] makes an important distinction between what he calls self-contained and purposive practices. He accuses MacIntyre of missing this important distinction. Miller believes that this distinction has implications for how the virtues – most notably, courage and justice – are understood and how they relate to the internal goods.

Miller claims that Macintyre's list of practices is so diverse that the notion of a practice is made more complicated than it should be. According to Miller, self-contained practices – for instance, chess and cricket – are entirely concerned with "the internal goods achieved by participants and the contemplation of these achievements by others".[34] Conversely, Miller believes that purposive practices serve other (usually) social ends. Miller thinks that MacIntyre's distinction between internal and external goods is well made. However, this is because MacIntyre focuses on games, such as chess, where the distinction is quite obvious. Miller explains that the internal goods gained through playing a fine innings of cricket would be "incomprehensible in the absence of the game itself". He then claims that "the standard of excellence involved....can only be identified by reference to the history of the game".[35] In other words, the sorts of things – particular skills, strokes, positioning of the bat and so on – that make an innings 'fine' have been developed through the history of the game by previous cricketers. One important point is that self-contained practices can only be judged by those who participate in them. In arguing that non-participants probably have insufficient knowledge to identify the internal goods, MacIntyre's claim seems to be excessively exclusive.

Miller continues by claiming that in the purposive practices of farming or the activities of physicists or historians, there is an external social purpose that helps to provide the point or *raison d'etre* of the particular practice. For instance, the social purpose of farming could be 'producing food for the community', while for physicists it might be 'discovering and finding evidence to support the truths of physics'. Judgement on the standards of excellence within these practices can legitimately be made from people who do not participate in the practice.

Miller's distinction makes MacIntyre's claims about the differences between the internal and external goods less convincing. In farming, for example, there is still the distinction between being an excellent farmer and the various extrinsic goods, such as, developing a good local reputation and money that could accompany success as a farmer. But on Miller's view, because farming has an important social purpose being an excellent farmer also concerns things that are external to that practice.

Miller illustrates his concern by referring to the example of medicine (which MacIntyre mentioned in *After Virtue*, but failed to develop). Actually stating what the internal goods of medicine are is not particularly straightforward. Perhaps it is 'being an excellent doctor'. However, Miller points out that this might mean different things. For instance, it could refer to 'someone who is excellent at healing the sick' or to 'someone who carries out the standards of the medical community in an excellent manner'. These two meanings might indeed diverge to a degree. If so, Miller argues that the practice will have fallen victim to professional deformation, he writes "A good practice here is one whose standards of excellence are related directly to its wider purpose".[36]

In self-contained practices such as chess or cricket, the rules and standards can only be assessed internally by practitioners taking part. Whereas with purposive practices, for example, farming, architecture or physics, the practice as a whole can be reviewed

by comparing it against the end it is meant to serve. Take medicine as an example. It is possible to compare different forms of medicine, for instance Chinese versus Western. Or it is possible to compare different forms of surgical techniques for say hip replacement operations. Standards of excellence relating to these forms of medicine or techniques may change and these changes may be made following a review of such comparisons. Adopting Miller's distinction between self-contained and purposive practices means that in purposive practices, the standards of excellence and internal goods will be related to the particular ends of the practice.

Miller believes that MacIntyre makes a mistake in assuming that all practices are the self-contained type (even farming, which seems to have a clear social worth). Miller believes that this assumption is supported by MacIntyre's examples and by MacIntyre's claim that the standards of excellence are only developed through internal debate with specific practices. It is this assumption that helps ground and make possible MacIntyre's account of the virtues.

For MacIntyre the virtues are personal qualities, dispositions or traits of character required to sustain the practices and achieve the goods internal to each practice. These goods may alter as practices develop. But newly suggested traits cannot simply qualify as virtues on the basis of some social goal or purpose.

However, Miller argues that the virtues should be understood as dispositions that sustain purposive practices. Thus any 'list' of the virtues must be formulated according to the social goals, ends and purposes that each practice is meant to serve. It follows from this that the virtues themselves are no longer independent or self-sufficient dispositions. Instead, they are dependent upon an understanding of a particular society's dominant purposes and needs. According to Miller, the main arena for the

manifestation of the virtues will be related to purposive practices – for instance, farming and medicine – and not towards self-contained practices.

Miller looks at two specific virtues, namely courage and justice. He asks, 'When do we think of people displaying courage? First, during wartime or on the battlefield. Second, when acting humanely in dangerous situations. Finally, when putting up with intense pain with equanimity. He believes these are central cases. One could also speak of courage as that quality displayed by, for instance, parachutists. But here he believes one might use the term 'daring' instead. This is because this activity – and others like it – is optional; people participate through choice. For Miller, a distinctly 'moral' term like courage does not appear to be warranted in these lesser cases. On this point, he writes

> Unlike courage displayed in the service of a valued end such as the saving of life or the defence of one's homeland, courage displayed merely for its own sake is hardly the genuine thing.[37]

Miller's conclusion is that plausible accounts of courage, justice and perhaps other virtues need to relate to purposive, not self-contained practices.

How does MacIntyre respond to Miller's criticisms? In short, MacIntyre rejects these. He believes that if practices are valued for their external purposes, then these activities are hostile or opposed to practices. According to MacIntyre, these types of activities are linked to modern economic systems, which are organised in ways that exclude the necessary features of practices.

MacIntyre also charges Miller with missing a crucial distinction, "that between a practice and the way in which it is institutionalized".[38] This distinction helps one to comprehend (a) how external and internal goods are related and (b) how the virtues relate to internal goods. MacIntyre admits that if, in *After Virtue*, he had focused in

greater detail on productive crafts, for example, fishing and farming, then this distinction and the above two points might have been better realized. He explains this point when he writes,

> The aim internal to such productive crafts, when they are in good order, is never only to catch fish...It is to do so in a manner consonant with the excellences of the craft, so that not only is there a good product, but the craft person is perfected through and in her or his activity.[39]

**T3 – The role and importance of a tradition of enquiry in morality**

**The threat of moral relativism**

One of the reoccurring criticisms levelled at MacIntyre's moral theory, as outlined in *After Virtue*, concerns the concept of a tradition. Briefly, the objection is that because his moral theory focuses to such an extent on the idea of a tradition, it collapses into a form of moral relativism. More precisely, the claim is that individuals find themselves trapped within a particular tradition. Because they lack the necessary intellectual and practical resources, they are unable to enter into dialogue and adjudicate between other traditions. The result is that individuals cannot free themselves from the tradition they find themselves in.

MacIntyre fails to deal with this possible objection in *After Virtue*. However, he picks up on it later in *Whose Justice? Which Rationality?* and *Three Rival Versions of Moral Enquiry*. It is pertinent to note that MacIntyre rejects this objection. Despite morality being essentially tradition-dependent and although the given in persons' lives derives from traditions, MacIntyre believes individuals are able to enter into debate and rational argument between contrasting traditions. Thus, in his view, moral relativism is avoided.

**On liberalism ignoring social and historical contexts in moral philosophy**

There may be some truth in MacIntyre's assertion that contemporary liberalism ignores the role of social and historical contexts in moral philosophy. However, it does not necessarily follow that because of this liberalism completely fails to acknowledge the

given – what is already present in one's life, through one's past, community and nation – in one's moral life. MacIntyre's provides a crude characterization of contemporary liberalism.

Perhaps I misunderstand MacIntyre, but he appears to confuse two points in his discussion of social roles and identities. First, he believes that all individuals have particular social identities. This is correct, I have no dispute with this claim. This means persons all have individual identities, in several respects persons are quite different. Second, MacIntyre claims that the good for one person *must* be the good for others who take on that role. The use of 'must' here is misplaced. Even if this claim was true, it should not be conceived as an obligation, although it appears that this is MacIntyre's conception.

More notable, however, is the fact that MacIntyre appears to confuse social roles with one's particular character. There are grounds for believing these are distinct. For example, it does not necessarily follow that Jack (the son of John) will share the same conception of the good as Brian (the son of Norman). Or that Bruce, a farmer, will share the same conception of the good as Frank, another farmer. These individuals might hold conceptions of the good containing certain items that appear on each of their lists. This phenomenon, however, might arise out of coincidence, experience (for example, knowledge of what is needed to be a successful farmer) or sheer luck. Examples of shared items include good health, sufficient money to live well, good, long lasting relationships with friends and enjoyable and stimulating jobs. Many people would include some (or all) of these items on their list of goods. But the many different particulars that make ones' lives unique – one's hopes, attitudes, fears and beliefs, not to mention the various pragmatic circumstances that shape human lives - ensure that many of us would will conceive of the good life in different ways. (Later in *After Virtue*,

MacIntyre says that the given in each of our lives gives us a different moral identity or particularity. Here, he seems to be acknowledging the uniqueness of individuals' lives.)

## Conclusions

MacIntyre's account of the virtues has been described and examined. I have interpreted his account presented in *After Virtue* to consist of 3 theses: the role and importance of a narrative conception of the self in morality; the meaning and nature of practices, goods and the virtues; and the role and importance of a tradition of enquiry in morality.

MacIntyre believes that moral philosophers have failed to socially and historically contextualize modern obligation-based moral theories. Such theorists have tended to ignore the role and importance of history and social theory in moral philosophy.

Instead of a liberal conception of the self, which contemporary liberal theory proposes, MacIntyre advances a narrative conception of the self. The latter conception focuses on the moral context, history and background circumstances of peoples' lives, which are unchosen, but which help to inform and make one's choices meaningful and comprehensible. According to MacIntyre, man is essentially a story telling animal.

I have provided MacIntyre's conception of a practice. A 'practice' is the name given to a complex series of human activities that strive towards standards of excellence and realize entities called internal goods. MacIntyre's examples of practices include chess and farming. For MacIntyre, a virtue is a disposition that: sustains practices; enables humans to achieve the internal goods of practices; ensures that humans continue on their search or quest for the good life; and help to provide humans with greater self-knowledge and knowledge of the good life for man. It is sometimes difficult to identify

the internal goods of a practice; MacIntyre believes that only those people who participate in the practice will be able to do this. The internal goods of chess could include the sorts of feelings and attitudes developed and sustained in those who play chess and take pride in aiming to be excellent at playing chess. Conversely, external goods include things such as wealth, power and prestige that can all be obtained by participating in other activities.

A tradition of enquiry contextualizes and situates the narrative conception of the self and the practices and virtues. A tradition can be seen as an intellectual argument that provides a way of understanding the value of practices. Traditions are dynamic and change over time; they shape practices and help them to live on through future generations. Practices are situated within and help to sustain a tradition of enquiry.

I have examined several objections levelled against MacIntyre's account. Perhaps the most notable is Miller's distinction between self-contained and purposive practices. Miller believes that purposive practices such as medicine serve social ends. Whereas, self-contained practices such as chess and cricket are entirely concerned with the internal goods of that practice and how participants can achieve the internal goods.

It should be clear by now that I share many of MacIntyre's concerns with modern moral philosophy. It seems to me that MacIntyre provides a rigorous and thought provoking account of the virtues. I believe that some of his ideas have value and application within nursing practice and nursing ethics. Thus, in the next Chapter, I apply some of his ideas to my conception of the virtue-based approach in nursing practice, which I proposed in Chapter 7.

## REFERENCES AND ENDNOTES

[1] This section draws information from 5 main sources: (1) A. MacIntyre, *After Virtue – A study in moral theory*, 2nd ed. (London: Duckworth, 1985); (2) J. Horton & S. Mendus, eds. *After MacIntyre – Critical Perspectives on the Work of Alasdair MacIntyre* (Oxford: Blackwell Publishers, 1994); (3) D. Miller, "Virtues, Practices and Justice" in *After MacIntyre*, pp. 245-264; (4) A. MacIntyre, "A Partial Response to my Critics" in *After MacIntyre*, pp.283-304; and (5) A. Mason, "MacIntyre on Modernity and How It Has Marginalized the Virtues" in *How Should One Live?* ed. R. Crisp (Oxford: Oxford University Press, 1996), pp. 191-209.

[2] I shall confine this discussion mainly to moral philosophy, thus ignoring in large part the subject of political philosophy.

[3] G.E.M. Anscombe, "Modern Moral Philosophy" in *Virtue Ethics* eds. R. Crisp & M. Slote (Oxford: Oxford University Press, 1997), pp. 26-44.

[4] Bernard Williams has written many articles and books, which critique our ordinary and the Kantian conception of moral obligation. And at least in some of his writings, he appears to criticise the idea that a single moral theory could (or should) resolve moral dilemmas; his view simply put is that the moral life for humans is far too textured, complex and rich for any single theory, with all its problems, to triumph over. However nor does he think it is plausible that any hybrid theory could succeed in this task. Because of these views he has been called an 'anti-theorist'. See for example, B. Williams, *Ethics and the Limits of Philosophy* (London: Fontana Press, 1985).

[5] I refer here to *A Short History of Ethics* (London: Routledge and Kegan Paul, 1967) and *Against the Self-Images of the Age: Essays on Ideology and Philosophy* (London: Duckworth, 1971).

[6] MacIntyre, *After Virtue*, p. 216.

[7] J. Horton & S. Mendus, "Alasdair MacIntyre: *After Virtue* and After" in *After MacIntyre – Critical Perspectives on the Work of Alasdair MacIntyre* eds. Horton & Mendus (Cambridge: Polity Press, 1994) pp. 1-15, p. 9.

[8] Horton & Mendus, "Alasdair MacIntyre: *After Virtue* and After", p. 9.

[9] Ibid.

[10] MacIntyre, *After Virtue*, pp. 218-219.

[11] MacIntyre, *After Virtue*, p. 187.

[12] Horton & Mendus, "Alasdair MacIntyre: *After Virtue* and After", p. 10.

[13] MacIntyre, *After Virtue*, p. 191.

[14] MacIntyre, *After Virtue*, p.188.

[15] MacIntyre, *After Virtue*, p.189.

[16] MacIntyre, *After Virtue*, p. 219.

[17] Ibid.

[18] This point is adapted from D. Miller, "Virtues, Practices and Justice" in *After MacIntyre*, pp. 245-264, p. 247.

[19] MacIntyre, *After Virtue*, p. 220.

[20] MacIntyre, *After Virtue*, p. 221.

[21] MacIntyre, *After Virtue*, p. 222.

[22] S. Mulhall & A. Swift, "Liberals and Communitarians" (Oxford: Blackwell Publishers, 1992), p. 90 in Horton and Mendus, *After MacIntyre*, p.11.

[23] Mulhall & Swift, "Liberals and Communitarians" (Oxford: Blackwell Publishers, 1992), p. 90 in Horton and Mendus, *After MacIntyre*, p. 12.

[24] Ibid.

[25] For example: N. Rescher, *The Coherence Theory of Truth* (Oxford: Oxford University Press, 1973); see the Chapter in: L. Johnson, *Focusing on Truth* (London: Routledge, 1992).

[26] R. Rorty, *The Consequences of Pragmatism* (Hassocks: Harvester, 1982); S. Haack, "Pragmatism" in *A Companion to Epistemology* eds. J. Dancy & E. Sosa (Oxford: Blackwells, 1992), pp. 351-357.

[27] A. Mason, "MacIntyre on Modernity and How It Has Marginalized the Virtues" in *How Should One Live?*, ed. R. Crisp, pp. 191-209, p. 195.

[28] Mason, "MacIntyre on Modernity and How It Has Marginalized the Virtues", p. 196.

[29] Ibid.

[30] Mason, "MacIntyre on Modernity and How It Has Marginalized the Virtues", p. 197.

[31] J. Rawls, *A Theory of Justice* (Harvard: Harvard University Press, 1971).

[32] A. MacIntyre, *Whose Justice? Which Rationality?* (London: Duckworth, 1988).

[33] D. Miller, "Virtues, Practices and Justice" in *After MacIntyre*, pp. 245-264.

[34] D. Miller, "Virtues, Practices and Justice" in *After MacIntyre*, p.250.

[35] Ibid.

[36] D. Miller, "Virtues, Practices and Justice" in *After MacIntyre*, p.251.

[37] D. Miller, "Virtues, Practices and Justice" in *After MacIntyre*, p. 253.

[38] A. MacIntyre, "A Partial Response to my Critics" in *After MacIntyre*, pp.283-304, p. 284.

[39] Ibid.

# CHAPTER 9 – MACINTYRE'S ACCOUNT OF THE VIRTUES AND THE VIRTUE-BASED APPROACH TO MORAL DECISION-MAKING IN NURSING PRACTICE

## Introduction

The conception of the virtues and the virtue-based approach to moral decision making in nursing that I explicated in Chapter 7 is a defensible and well-argued account. Having examined MacIntyre's account of the virtues in general ethics, it is quite clear that some of his ideas, for example, those concerning a narrative account of the self and the conception of a practice, could be applied to nursing practice. Therefore this is what I aim to do in this Chapter. I intend to provide further theoretical and philosophical foundations for the plausibility and viability of a strong virtue-based approach to nursing practice.

## Nursing practice, narratives and morality

In Chapter 2, I described and examined some of the emotions that persons can feel during periods of illness. The process of hospitalization can intensify such emotions. I focused on the following emotions: anxiety, fear, powerlessness, vulnerability and dependence on others for help. Patients can describe and express their feelings about illness in the form of a narrative. The virtue-based approach encourages a nurse to listen to patient's narratives, because the emphasis is not solely upon the nature and consequences of actions. Rather the focus is also on patient's character traits and this approach recognizes the value and worth of emotions in one's moral life. Central to the virtue-based approach is the need for nurses to inculcate the virtues, which aims to develop and maintain morally good interpersonal responses. MacIntyre's narrative

conception of the self recognizes the importance of interpersonal responses. Nurses and patients can better understand who they are through an examination and reflection of interpersonal responses.

For MacIntyre, the central question in one's moral life is 'how am I to understand who I am?' Thus, questions and reflections concerning personal identity and self-awareness regarding both intrapersonal and interpersonal responses become crucial features of the moral life. Who and what I am concerns context and one's role as a nurse.

In Chapter 2, I mentioned the empowering effects that listening to patients' narrative accounts of illness can have. The virtue-based nurse desires to know about and understand the patient's lived experience of illness. Take a patient with chronic rheumatoid arthritis (CRA) as an example. The nurse wants to discover how the CRA affects the quality of the patient's life. How do inflamed joints affect her activities of living? What sorts of problems of living are caused by the CRA? Note that the nurse will gather and assimilate information about physical and emotional needs. Nurses who wish to learn about such stories from patients will require patience because one needs to spend time building up such a profile. But such nurses will be motivated to spend time with the patient, ask relevant questions, listen to the patient's responses that tell a personal and emotive story and aim to understand the patient's needs. This process is not simple. It requires a certain degree of enthusiasm for nursing, dedication to the role of being a nurse and the exercise of virtues such as patience, tolerance and industriousness. The nurse wishes to understand such a narrative account of the patient's illness to help situate the patient at the centre of care. The current in vogue ideal of patient-centred care surely needs to take seriously the idea that nurses should be listening to patients' narrative accounts of illness. The virtue-based approach through

self-reflection and reflection of the patient's needs and interests promotes and facilitates answers to the questions 'how in this situation can I help my patient' and 'how in this situation should I respond to my patient's needs?'

Part of the effect of listening to a patient's narrative account of illness should be that it becomes easier to view a patient's time on the ward as only one moment out of the person's whole life. The narrative conception of the self helps one to think of patients' pasts, presents and futures. For instance, a nurse is caring for a patient named John. The present is John's time spent on the ward as a patient with CRA undergoing investigations with the aim to alleviate swelling and pain. But John is 65 years old, he has a past. The nurse knows little about his past, some factual information is written in the medical and nursing documentation. But there is no sense of John as a person, his values, beliefs and life plans. Nor can anyone know what will happen to John in the future; once he has been discharged, no one knows what might happen regarding his life and illness.

MacIntyre's account of morality is context dependent, it is a particularist approach rather than the universal approach adopted by obligation-based moral theories especially Kantianism. MacIntyre's account focuses on the moral context, history and background circumstances of one's life that provide meaning and facilitate understanding of possible decisions, choices, actions and ways of responding to others. The vast range of morally relevant features help to illuminate the context and specific circumstances of individual, unique situations and interactions. Of course, being there does not guarantee that a nurse will see these features; this will depend in part on moral perception, which the virtue-based approach heightens.

In response to the question 'what ought I to do?' a nurse can search for her identity by asking questions such as 'who am I?' According to MacIntyre, one goes on a quest for the unity of one's life. Such a quest requires a social context. Questions such as 'what is the good for me as an individual nurse? and 'what is the good for this team of nurses?' need to be posed.

According to Horton and Mendus[1], although answers to 'what ought we to do?' involve asking what one should do as an individual, they concern more importantly discovering who one is in relation to other people. Who am I in relation to other nurses? Who am I in relation to a patient? Clearly, the patient knows me as a nurse. But am I a distant professional, a friend or a carer who exercises the virtue of friendliness? In response to these sorts of questions, at least two things are required: reflection (including self-reflection) and self-awareness. According to the virtue-based approach, nurses should engage in reflection of other people, oneself and the world one inhabits. Might self-reflection promote self-awareness? I believe it helps. Developing self-awareness is crucial to the virtue-based approach; an awareness of one's good and bad traits of character, of motives and desires for being a nurse, of ideas regarding the role of a nurse and of the ends of nursing are all important topics for reflection.

**Nursing as a practice, its internal goods and the virtues**

MacIntyre's conception of a practice is complex. Could nursing be a practice in the MacIntyrian sense? Is nursing a complex and coherent form of socially established co-operative human activity? How complex is nursing? It would be easy for me –a nurse - to assert that nursing is complex. But how is 'complexity' to be evaluated? Nursing practice involves many activities and practices, which nurses perform. There are innumerable moral tensions and conflicts, which require decisions and choices to be made.

Complexity is one requirement of a practice on MacIntyre's view. Nursing abounds with complex moral and clinical decisions. It is reasonable to suggest that nursing is a form of complex, human activity. I also suggest that nursing is socially established. It is organized at a social and community level and nurses' activities are regulated at State level. In a sense then, nursing is co-operative as well.

MacIntyre was uncertain whether medicine was a practice; it would have been interesting and fruitful if he had debated this further. Miller[2] also thought medicine problematic, because of the difficulty in identifying internal goods. Although on Miller's view, medicine, since it has a definite social goal – to help, heal and care for ill persons – can be seen as a purposive practice.

Especially in the light of Miller's distinction between purposive and self-contained practices, it seems to me that medicine should qualify as a practice. For instance, it is co-operative human activity and coherent in that everyone should be working towards set ends. It is complex in the sense that it is grounded in the sciences, but also necessitates many other skills and abilities. If medicine is a practice, then perhaps nursing is too.

Sellman[3] thinks that there is a strong case for considering that nursing is a practice on MacIntyre's view. Sellman claims that the internal goods of nursing could derive from, for example, helping others, which is something those entering the profession often refer to. For example, a recent study using discourse analysis[4] investigated reasons why people want to be mental health nurses as opposed to, for example, general nurses. Six final year undergraduates constructed their own stories. One example is:

> I've enjoyed it so much better than general when I've been going

> through my training and I really do feel its my type of person is to sit and talk to patients, and you've got time in psyche... [5]

Other reasons referred to finding out that one had 'something to give'. The suggestion here could be that one wants to help others in some way deal or cope better with mental distress.

Furthermore, Sellman claims that other internal goods could be important

> for those who can be identified as good nurses and that these internal rewards become apparent as the student of nursing moves from mere performance of tasks to a position of immersion in the wider role of nursing.[6]

It would have been useful if Sellman had managed to explicitly identify another internal good, because although I have an idea of the sorts of things he has in mind, one is not sure. Perhaps Sellman was referring to the sorts of values and positive emotions that develop and find expression in more experienced nurses who find an affinity within nursing. If so, these feelings are hard to put into words.

Further support for identifying the internal goods of nursing could be obtained by asking nurses. For example, the 3 empirical studies[7] presented in Chapter 2 that examined the role of the nurse. The themes that were identified in these studies were: the need for nurses to respond to patients as individuals; nurses to demonstrate respect towards patients; nurses should make themselves available to patients; nurses should voluntarily decide to spend time with patients, ask questions and listen to patients' responses; and nurses should demonstrate certain 'qualities' (on my view, moral virtues) such as kindness, patience and honesty. According to empirical studies that examine the views of patients and patients' relatives[8], these remarks in large part define a 'good' nurse. The

virtue-based approach helps to promote a helping nurse-patient relationship, indeed if the virtues are exercised in this relationship, for example, kindness, courage, justice, and respectfulness then I refer to this relationship as virtue-based.

Practices seek to achieve standards of excellence. It has been noted that nursing from a virtue-based viewpoint strives for moral (and clinical) excellence. Virtues on MacIntyre's view are those acquired traits of character that sustain the practices and help persons acquire the internal goods.

I need to return to the question of nursing and its internal goods. What might form the internal goods of nursing? What counts as doing nursing well? In the literature in Chapter 2 regarding being a good nurse, the virtues were at the core of these descriptions. I believe that the internal goods of nursing relate to certain positive emotions felt by nurses. For example, the emotional responses and feelings in a nurse when she acts, thinks and feels in morally virtuous – for instance, kind, just and courageous – ways; when she recognizes and believes that her nursing care is morally (and clinically) excellent because of the virtues. When through kindness and patience (and perhaps courage) a nurse battles hard to alleviate a patient's pain, when through patience, industriousness and kindness a nurse succeeds in helping a patient to sleep and when through kindness, patience and gentleness a nurse succeeds in healing a patient's pressure sore. Nurses ought to feel proud of themselves when they manifest the virtues on a habitual basis. It is also immensely satisfying on an emotional level for a nurse to receive sincere gratitude from a patient or a patient's relative for the excellent nursing care that one has given. When the virtues are exercised, these feelings – the internal goods of nursing – are achieved and the practice of nursing is sustained.

In short, I suggest that the development and sustenance of a virtue-based helping relationship, the pursuit and implementation of virtue-based moral decision-making and the positive feelings of value, worth and gratitude experienced by nurses can be seen as examples of the internal goods of nursing.

MacIntyre claims that individuals cannot simply decide what acting well means to them, acting well is to be conceived in terms of the particular practices. MacIntyre would reject the idea that an individual nurse can and should work out her own conception of acting well and the good. These aims need to be achieved with reference to the practice of nursing and the team of nurses working in the environment. According to MacIntyre, there needs to be a shared conception of the good and agreement on what the ends of nursing should be and what the internal goods of nursing are.

How can a nurse know what a virtue is or which traits of character are virtues? I discussed this question in detail in Chapter 7. Now, in tandem with the use of judgment and moral wisdom, one can add that a nurse needs to understand how a particular trait of character relates to and promotes the practice of nursing or the specific activity that forms part of the practice of nursing.

On MacIntyre's view, the virtues, for example, kindness and justice will sustain the practice of nursing. Exercising the virtues will help nurses to achieve the internal goods of nursing. Self-reflection and reflection about nursing, the role of the nurse and the internal goods of nursing will help nurses to identify which traits are virtues. The virtues will help nurses to search – go on a quest – for the good life, for example, they can ask questions about the nature of being a good nurse, the meaning and nature of good nursing care and how good interpersonal responses can be formed and sustained. Self-

reflection and reflection are fostered by the virtues. Moral wisdom, in particular moral perception, is promoted and heightened by self-reflection and reflection of everything that surrounds a nurse. Nurses can learn that exercising the virtues have positive effects on the lives of patients, virtuous nurses can achieve the internal goods of nursing and such nurses can see that exercising the virtues is a good way of being a nurse.

MacIntyre believes that unless there is a single shared conception of the good life, the virtues will be marginalized. He believes that if the virtues are neglected, if for example, justice is only understood as an ethical principle or obligation, then the virtues will be marginalized and wither away. However, Mason[9] disagrees with MacIntyre. According to Mason, the virtues can still flourish in different practices as long as the individuals within each practice share a conception of the good and cooperate to pursue the good. For example, a team of 10 nurses on a medical ward cooperate to exercise the virtues of compassion, courage, kindness, justice and respectfulness. All of the nurses agree that these virtues are crucial to promoting the good including the survival, recovery and faring well of the patients. The nurses realize that other virtues might be important given the particular circumstances of each situation. But they cooperate to exercise the aforementioned virtues so that they can achieve the internal goods and the practice of nursing is sustained. On Miller's view, a nurse can review the practice of nursing by comparing actions and behaviours with the end it is meant to serve. The standards of excellence relate to the particular ends of nursing.

The virtue-based approach and its focus on exercising the virtues can help a nurse to achieve moral excellence. However, adopting the obligation-based view does not mean that a nurse will be unable to achieve moral excellence. But the obligation-based approach does not focus on this aim; instead it seems to me that it strives towards moral

competence. Note that the exercise of the moral virtues and the virtue-based approach can also facilitate the delivery of clinical excellence (Chapter 7). And if there is a focus on the intellectual virtues then clinical excellence will be promoted.

### The virtue-based approach as a tradition of enquiry

Regarding the MacIntyrian idea of a tradition of enquiry, each individual nurse is part of a history; one inherits much of who one is from others. Each person is a bearer of a tradition of enquiry, an intellectual set of ideas – an argument – that situates the practice of nursing (see Figure 1). The history of nursing as a profession, the history of nurse education and the histories of each person entering the nursing profession all operate within a tradition of enquiry. Traditions are dynamic; they change to meet the needs of generations. The philosophical argument that is the virtue-based approach is an example of a moral tradition of enquiry; the biomedical model is a scientific or biomedical tradition of enquiry. The current emphasis on patient-centred and collaborative care and the need for morally excellent care in response to patients' needs and interests provide reasons to change the intellectual landscape or perhaps a mini paradigm shift is required.

## Conclusions

I examined MacIntyre's work on the virtues so that I could further ground my account of the virtue-based approach to nursing practice. This approach includes the development and sustenance of a virtue-based helping relationship and the notion of virtue-based moral decision-making. The latter is characterized in 3 parts: (1) the exercise of the virtues; (2) the use of moral judgment; and (3) the use of moral wisdom – moral perception, moral sensitivity and moral imagination.

There are notable problems to be addressed with regard to the virtue-based approach. These include the conflicts problem and the threat of moral relativism. I have provided a defence of these problems in Chapter 7.

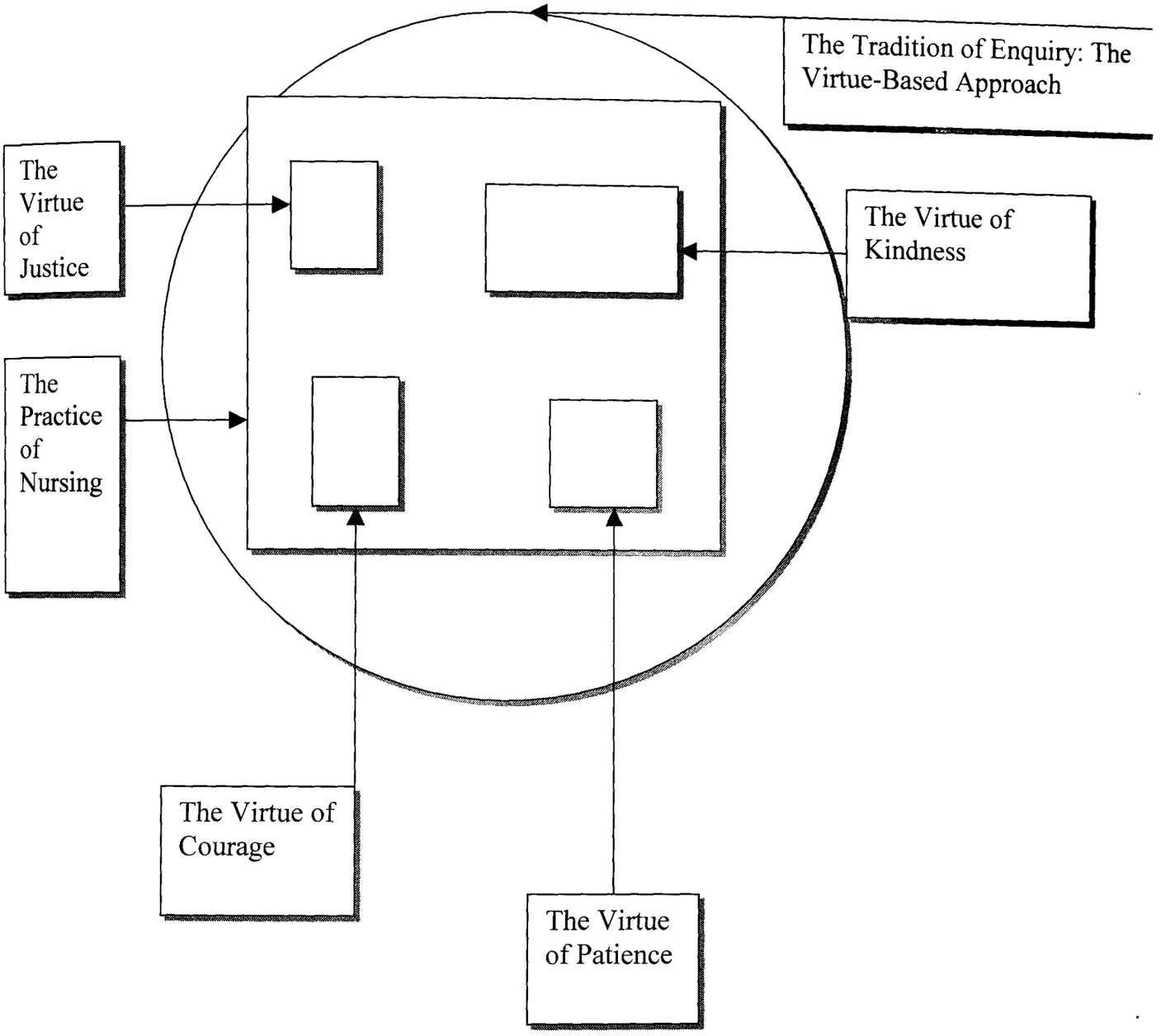
At the end of Chapter 7, I summarized the merits of the virtue-based approach to nursing practice. I shall repeat these here: (1) in clinical practice, nurses utilize the language of the virtues, thus it is sensible that a nursing ethics utilizes the same vocabulary; (2) strong virtue ethics is viable because adequate action-guidance is provided from the virtue and vice terms, plus virtue ethics comes up with rules, the v-rules such as 'be honest' and 'act kindly' that can help a nurse decide how to *act* and *be* towards a patient; (3) unlike obligation-based moral theories such as deontology and consequentialism the virtue-based approach while accepting the importance of consequences, outcomes and results does not over focus on these morally relevant features; (4) the virtue-based approach acknowledges the important role played by emotions in the moral lives of patients and nurses; (5) no assumptions are made concerning the resolvability of moral dilemmas and the phrase 'morally right action' is not conflated to mean 'morally good deed'; (6) the virtue-based approach recognizes that the young including novice nurses need to learn and be taught how to be moral; (7) the virtue-based approach as a tradition of enquiry moves away from the still dominant biomedical model, the former accommodates the contemporary agenda of patient-centred, collaborative and holistic nursing care far more than the disease and diagnosis focused biomedical model; and (8) the virtue-based approach realizes the need for and importance of nurses utilizing judgment and moral wisdom in nursing practice.

I now add that I conceive nursing as a practice on MacIntyre's view, although following Miller I view nursing as a purposive practice, because it has clear social goals. The

internal goods of nursing might be obscure and difficult to articulate. However, it is fundamentally about nurses wanting to be morally good and wanting to carry out one's role to a high moral and clinical standard. The sorts of positive emotions one feels, the praise and admiration from others and the memorable sense of achievement that one gains from acting well and helping patients survive, recover and fare well through and beyond illness are, in my view, plausible candidates for the internal goods of nursing. These feelings and responses cannot be achieved by other means. In short, the internal goods of nursing can be found in the development and sustenance of a virtue-based helping relationship and the practice of virtue-based moral decision-making.

The virtue-based approach to nursing practice is a tradition of enquiry. As shown in Figure 1, the practice of nursing is contextualized and situated within the virtue-based approach. Nurses can identify the virtues in a number of ways. For example, by thinking hard about the conception of a virtue given in Chapter 3, by reflecting about the role of a nurse and by developing a shared conception of the good life and thinking about the ends of nursing. Exercising the virtues of, for example, justice, kindness, patience and courage can help a nurse to achieve the internal goods of nursing. Furthermore, exercising these (and other) virtues will contribute to the sustenance of the practice of nursing and the internal goods and prevent the marginalization of the virtues.

Figure 1: A representation of the virtue-based approach, the practice of nursing and the virtues of justice, kindness, courage and patience.



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# CHAPTER 10 – CONCLUSIONS

## Introduction

In this final Chapter, I summarize the argument. I reiterate some of the problems of the virtue-based approach in nursing including conflicts between virtues. I then consider some points for further enquiry and research. Finally, I highlight some of the merits of the virtue-based approach including its position on moral dilemmas/moral remainder, I examine Hursthouse on 'morally right decision/right moral decision' and I examine the topic of moral education.

### The argument summarized

Life threatening, serious and minor illness can affect people throughout the lifespan. Illness forms part of a person's life; it is a personal phenomena. A person can feel one or more negative emotions caused by illness. These include anxiety, fear, helplessness, powerlessness and vulnerability. Admission to hospital or being cared for at home by people who are effectively strangers can intensify these feelings. Illness enforces dependence on others for help. One needs help to survive illness, recover from it and fare well during and beyond illness.

One of the recognized roles of a nurse is to help and care for patients and promote independence in patients. To this end, the development and sustenance of a therapeutic nurse-patient relationship is of crucial importance. To facilitate such a helping relationship, the literature suggests that nurses require several skills, attributes and qualities. These include well-developed verbal and non-verbal communication skills, honesty, kindness,

patience and trustworthiness. These qualities are particularly important in the light of the current trend towards collaborative and patient centred-care.

Instead of these traits of character being conceived in terms of skills or qualities and left at that, these traits are examples of moral virtues. It is therefore necessary to turn to moral philosophy and examine the nature of the virtues. The virtues were at the core of ancient Greek ethics most notably in Aristotle's[1] ethics. In this thesis, a moral virtue is conceived as a morally good character trait to acquire and exercise. Traits such as kindness dispose the possessor to habitually act, think and feel in certain ways, in this case kind ways. Moral virtues are examples of moral excellences and as such people who inculcate the virtues deserve praise and admiration from other people. The virtues differ depending on roles and between societies and cultures. However, exercising the moral virtues is valuable because the possessor and benefactors tend to do well from virtuous activity.

Since the Enlightenment, obligation-based moral theories have developed and within contemporary general ethics these theories are popular and receive widespread attention in the literature. Whilst it is clear that obligations, rules and principles, the nature of the act and the consequences of actions are morally important features obligation-based theories have several well-established flaws. Regarding consequentialism, these include difficulties in predicting the actual consequences of actions and omissions and an over focus on the notion of the 'Right' including an extreme focus on 'right action'. Furthermore, act, rule and indirect forms of consequentialism omit to discuss and take seriously several other morally important features. For example, they fail to provide a rich account of moral character, tend to gloss over the question of moral education, that is, how the young learn to be morally good adults and fail to acknowledge the important role played by emotions in the moral life of people. Deontology does not provide adequate action-guidance until its

second premise, it uses complex evaluative language such as 'harms' and 'interests' and it fails to tell one how to settle conflicts between moral duties. Because of these flaws and omissions, obligation-based moral theories in general ethics are incomplete and hence inadequate.

The question is, 'where should one turn in order to discover a more complete account of the moral life?' My response is to virtue ethics, the moral theory that has the virtues at its core. The aims of virtue ethics include providing a detailed account of moral character, resisting making the assumption that all moral dilemmas are resolvable and providing a satisfactory account of moral education. Supplementary and strong versions of virtue ethics have been developed. Strong versions of virtue ethics have not been proposed in medical/health care ethics. This deficit is connected to one of the common criticisms levelled against virtue ethics, that it is unable to provide adequate action-guidance; in other words it is unable to tell people (nurses) what to do. But thinking about the nature and meaning of the virtue and vice terms and the v-rules set forth by Hursthouse[2] means that virtue ethics does indeed provide adequate action-guidance; at least it is as adequate as the action-guidance prescribed by consequentialism and deontology. A strong version of virtue ethics is therefore viable and more plausible than some critics acknowledge. However, several other problems afflict virtue ethics including the charge of moral relativism, how it accounts for excessive virtue and how conflicts between virtues can be resolved.

Despite the recognition that nurses should display the moral virtues and the plausibility of a strong virtue ethics (at least in general ethics), in nursing practice and nurse education obligation-based moral theories remain extremely popular and widespread. Possible reasons for their popularity include the compatibility between the empirical epistemological

paradigm of medicine and the outcome-centred perspective of consequentialism and the compatibility between rule-based deontological ethics and the rules laid down by institutions such as hospitals.

An examination of moral character is neglected in the literature on nursing ethics. The 'four principles' approach is popular in the teaching of ethics to students of nursing and in the literature. The latest edition of Beauchamp and Childress' *Principles of Biomedical Ethics*[3] has responded to criticism of earlier editions by including a chapter on the role of the virtues in biomedical practice.

Disadvantages of obligation-based moral theories in nursing practice include an over focus on the nature and consequences of actions/omissions, assumptions about and an emphasis on moral dilemmas and their resolution, ignorance of the role emotions play in the moral lives of patients and nurses, lack of guidance regarding conflicts between obligations, for example, respect for autonomy and beneficence, the apparent incompatibility between the nature and aims of obligation-based ethics and the current health agenda towards patient centred and collaborative care and the ignorance and unrealistic attitude demonstrated towards the role of judgment and moral wisdom in the moral lives of nurses.

The relationship between illness and patients' emotions particularly vulnerability and dependence on others for help, the importance of moral character, the value of the moral virtues and the use of judgment and moral wisdom can be taken further and contextualized within contemporary nursing practice. There is some evidence to suggest that nurses do not utilize obligation-based ethics, for example principle-based ethics, in moral decision-making. Instead, judgement, intuition and instincts are relied upon. The

virtue-based approach suggests that nurses ought to utilize judgement and moral wisdom – characterized as moral perception, moral sensitivity and moral imagination – so that morally good decisions can be made.

Morally relevant features of situations, experiences, interactions and observations include the outcomes of actions, intuitions, moral rights, moral virtues, intentions and motives, religious beliefs, past experiences and clinical information. Morally perceptive nurses are able to see such features and discern meaning in them. Morally sensitive nurses assimilate this understanding, act upon it and respond to patients' needs and interests in morally good ways. Moral imagination can be utilized by nurses to reflect on what it might be like to be a patient in a specific set of circumstances; these thoughts can help a nurse to find a broad and diverse range of practices, interventions and activities that can help patients.

Three features characterize the virtue-based approach to moral decision-making: (1) exercising the moral virtues, for example, compassion (2) utilizing judgment and (3) utilizing moral wisdom. The emphasis is on helping a patient to survive illness, recover and fare well from illness. The virtues are concerned not with right action but with acting morally well, for example, kindly, justly, and patiently. The virtue-based approach *does* take into account the nature and consequences of actions/omissions. Other positive features of this approach include a focus on intrapersonal and interpersonal responses, the role played by emotion including moral remainder in the moral lives of patients and nurses and the use of judgment and moral wisdom in helping nurses to make morally good choices and decisions in particular situations with different circumstances. The virtue-based approach can be described in short as context-dependent, relational and particularist for the reasons stated.

Problems of the virtue-based approach in nursing include assumptions about the nature of virtues and goodness, ambiguity and disagreement in identifying the virtues, uncertainty regarding how to account for excessive virtue, for example, being *too* honest with a patient and being unable to settle conflicts between virtues such as respectfulness and justice. However, there are also many merits. These include the compatibility of this approach with the language of the virtues and vices used by nurses in practice, adequate action-guidance provided by the v-rules and the content of the virtues, the wider range of morally relevant features that this approach takes into account, its acknowledgment that some moral dilemmas are irresolvable or tragic and a recognition that even so-called resolvable dilemmas mean that virtuous nurses will feel moral remainder, its emphasis on moral education and its acknowledgment that 'high' quality nursing, indeed patient-centred and collaborative care, require a particularist and relational nursing ethics that promotes and encourages the use of moral judgment and moral wisdom in moral decision making.

While the philosophical foundation for this virtue-based approach is adequate, the work of MacIntyre provides a more secure, perhaps deeper, level of grounding. MacIntyre's account of the virtues as set forth in *After Virtue*[4] is interpreted in the form of 3 theses: (1) the role and importance of a narrative conception of the self in morality, (2) the meaning and nature of practices, goods and the virtues and (3) the role and importance of a tradition of enquiry in morality. MacIntyre's account of the virtues is relevant to contemporary nursing practice. For example, his account recognizes the importance of allowing patients to tell their narratives, it acknowledges the importance of interpersonal responses and it realizes that questions about personal identify are fundamentally important, for instance, 'who am I?' and 'how do I relate to my colleague?' MacIntyre's account is particularist, relational and context dependant, most suitable for the virtue-based approach to moral decision making in nursing practice.

Nursing is conceived as a purposive practice; it is a complex and coherent form of socially established human activity that aims at providing social goods and demonstrating human excellences. While it is far from simple to articulate the internal goods of nursing, it is plausible to suggest that these relate to nurses feeling certain positive emotions. These emotions occur when one acts, thinks and feels in morally excellent ways in an attempt to help a patient survive illness and then recover and fare well from illness. The development and sustenance of a virtue-based helping relationship, the pursuit and implementation of virtue-based moral decision-making and feeling valued, for example, receiving gratitude from a patient or relative, are examples of the internal goods of contemporary nursing practice. Self-reflection about the role of a nurse, one's desires as a nurse and the ends of nursing shed light on which traits of character are virtues. Nurses who exercise the virtues help to sustain the practice of nursing. The virtue-based approach is conceived as a tradition of moral enquiry, the practice of nursing is contextualized and situated within this tradition of enquiry. Exercising the virtues, for example justice, will prevent the marginalization of the virtues.

**Problems with the virtue-based approach**

Some of the problems of the obligation-based approach that were examined in Chapter 6 have been repeated in the above summary. In summarizing the argument, I have also repeated some of the problems of the virtue-based approach to moral decision-making in nursing practice that I examined in Chapter 7.

The problems of the virtue-based approach will be listed in the same sequence as that given in Chapter 7. These are: (a) assumptions made about virtues, moral goodness and the meaning of 'virtuous'; (b) the difficulty inherent in identifying the virtues and the charge of moral relativism; (c) how one can account for persons exercising a virtue, for example

honesty, to an excessive degree; (d) the criticism that virtue ethics and the virtue-based approach fails to provide adequate action-guidance; and (e) how to settle conflicts between virtues.

I shall now discuss (d) and (e) in more detail, but note that I also responded to these problems in Chapter 7.

**Inadequate action-guidance from virtue ethics and the virtue-based approach**

Supplementary virtue ethics is plausible because it combines the two different approaches, deontic (obligation-based) and aretaic (virtue and vice-based). But I believe that supplementary virtue theory is merely an obligation-based moral theory with a slogan attached saying something like 'oh, don't forget to take moral character into account'. I reject the view that people can derive adequate action guidance from evaluative and inflexible moral obligations, rules and principles. It seems to me untrue to suggest that obligation-based ethics provides adequate action-guidance, while claiming that virtue ethics and the virtue-based approach cannot. Responses from a recent Delphi study support Hursthouse's[5] claim that adequate action guidance can be obtained from thinking about the meaning of virtue and vice terms. In this study, the language used by nurses on a daily basis included virtue and vice terms such as 'honest', 'fair', 'well', 'good' and 'care'.[6] The use of such terms helps nurses to know how to *be* and also what to *do*. From my nursing experience, it is true to say that (at least some) nurses use language such as 'that nurse acted *badly*', 'as a nurse, I need to provide *good* nursing care' and 'it is important to be *fair* when delivering nursing care'. It has been noted how patients associate 'high' and 'good' quality nursing care with the exercise of moral virtues such as kindness and honesty. It is inaccurate to suggest that the language of the virtues and vices is strange or rare in nursing practice. It is actually very commonplace.

Furthermore, Hursthouse's v-rules thesis is simple, yet also inspiring. She is correct to suggest that the virtues and vices prescribe action guidance. For example, 'do what is *just*', 'be *kind* to patients', 'do not be *unfair* to patients' and 'be *respectful* towards patients'. To be critical for a moment, perhaps one could claim that Hursthouse is making an unnecessary concession to obligation-based ethicists who demand action-guidance in the form of moral obligations, rules and principles. Hursthouse developed the v-rules thesis as a response to the specific objection that virtue ethics, because it does not produce *any* rules, fails to provide adequate action guidance. However, she demonstrates that virtue ethics does produce rules for action. Moreover, the v-rules provide action-guidance that is on a par with the action-guidance prescribed by the one rule of act-consequentialism or the plurality of rules produced by the various forms of deontology.

**What about clinical skills?**

In relation to the charge of inadequate action-guidance, does discussion of the moral virtues ignore the need for nurses to possess good clinical skills?

Cultivating and exercising the moral virtues will ensure that nursing care is morally excellent. However, nursing is also a practical activity because the actual interventions/treatments/activities that constitute the work of nurses need to be physically *carried out* by nurses. How can the moral virtues help achieve clinical competence? I noted in Chapter 7 that virtue-based moral decision-making, especially the use of moral wisdom, can help a nurse to think of a broad and diverse range of activities that can help a patient. These activities include effective clinical interventions and pharmacological treatments. The motive is to find as many ways as possible to help a patient survive illness and recover and fare well beyond illness. Clinical nursing is not ignored even if the focus is just on the moral virtues.

A second response is to refer to Aristotle's distinction between moral and intellectual virtues (as noted in Chapter 3). Aristotle held that theoretical knowledge (*episteme*) and practical wisdom (*phronesis*) were intellectual virtues. Practical wisdom can be broadly understood to mean the practical skills and abilities that are needed to plan and lead a successful human life. In the context of nursing, skills and abilities that help a nurse to organize, plan and deliver care are important to being a 'good' nurse. In tandem with the moral virtues, these can help a patient to survive illness and recover and fare well beyond illness.

Theoretical virtue could also be conceived in a similar way. This refers to the wide range of theoretical knowledge needed by nurses to be successful in carrying out their roles. This knowledge base is drawn from several disciplines. For instance, anatomy, physiology, law, ethics, psychology, sociology, politics, evidence-based care and philosophical skills such as critical thinking and the ability to evaluate arguments. Furthermore, clinical skills such as taking and recording vital signs, applying a bandage and administering medications could be seen as practical virtues needed to be a good, successful nurse. The point about viewing the aforementioned as virtues is two-fold. First, their relevance to whether patients are able to fare well or not is clearly understood. And second, the virtues – moral and intellectual - all aim at human excellence. In short, the virtuous nurse is concerned with developing and maintaining morally and clinically excellent care.

**Conflicts between virtues**

Conflicts between virtues should be expected given the moral complexity of human lives. An adequate normative ethics will realize that conflicts between obligations, rules, principles and/or virtues will arise in part because of the personal and subjective nature of

human lives. Nursing practice is value-laden and abounds with morally dense, complex dilemmas and tensions.

The action-guidance available from thinking about the meaning and nature of the moral virtues, for instance courage, justice and kindness, will mean that nurses do have an idea of what to do in difficult situations. The v-rules also provide action-guidance. Furthermore, nurses will value different virtues. According to the virtue-based approach to moral decision-making, nurses will utilize judgement and moral wisdom to ascertain and comprehend the range of morally relevant features within a specific situation or interaction. Depending on a nurse's evaluation of the aforementioned, she might decide to be just rather than kind, because she values justice as a virtue more than kindness in this particular situation.

The virtues are excellences of character, admirable and praiseworthy traits that help their possessor and others to lead morally good lives. Choosing between virtues can be problematic; this is one reason why the use of judgment and moral wisdom is so important in the moral lives of nurses and patients. A decision may have to be made between acting justly or kindly. Both these sorts of actions are examples of acting virtuously. The patient will be helped, but in different ways. It would be different if the choice was between acting from a virtue (say, kindness) and acting from a vice (say, cruelty). The former is morally preferable to the latter. To end, it would also be prudent to act from the virtue of respectfulness and ask the patient for his preference. This is sensible (given the caveats that the patient is an adult and has decision-making capacity), especially with the current health agenda that focuses on collaborative and patient-centred care and promoting the empowerment of patients.

## Areas for further research and enquiry

### Research on identifying the virtues and conflicts between virtues

Empirical nursing research utilizing questionnaires, grounded theory and ethnography could examine a series of topics including the identification and value of virtues. Moreover, it would be profitable for researchers to investigate the nature of conflicts between virtues and gather information from nurses and patients regarding their views on these complex phenomena. Further philosophical enquiry on all of these topics is also needed.

### Research on the intellectual virtues, judgment and moral wisdom

In this thesis, I have neglected to sufficiently examine the role of intellectual virtues in nursing practice and their relationship to moral virtues. While it is clear that the moral virtues are crucial to the development of a virtue-based approach to nursing practice, the role of the intellectual virtues requires further scrutiny. Empirical research and philosophical enquiry regarding how nurses utilize practical wisdom and the role of judgment and moral wisdom in the moral lives of nurses and patients would prove invaluable to the development of a rigorous virtue-based approach to nursing practice.

### Virtue ethics and blame

Obligation-based ethics are stringent theories that demand a lot from people. Act-utilitarianism has just one rule, but deontology has a plurality of rules. In combination, these theories tell people that many acts are impermissible or obligatory. There is plenty of scope for people to fail to meet the demands of these rules. If a person does not meet such demands, then, according to these theories, she has failed and is morally (and perhaps legally) blameworthy and culpable, depending upon her intentions and the outcomes of the acts/omissions. Virtue ethics would view this differently. (I say 'would' because I failed to identify any literature on this topic.) The virtue ethics view is pertinent to

nursing because contemporary nurses practise in an environment that conceives 'good' practice in a legalistic sense as well as in a moral sense. Of course, virtue ethics aims to motivate nurses to cultivate and exercise the virtues, so that the possessor (the nurse) and the benefactor (the patient) can fare well in life. And if a nurse is despicable (for example, violent, nasty or cruel) then he acts viciously and deserves blame. He should feel moral remainder - emotions such as remorse, guilt and regret - for being such a nurse and doing such deplorable and unpleasant deeds (however, he might not feel these emotions because he is not virtuous). It is unfair to claim that virtue ethics is lenient on those who do horrid deeds; it clearly does not ignore the notions of blame and responsibility. Virtue ethics and the virtue-based approach encourages people to be virtuous, because it realizes that many people are capable of being vicious. But virtue ethics does not aim to make people feel guilty or uncomfortable for being unable to act in accordance with moral obligations, rules or principles. Part of the reason for this view is that people who have 'failed' to act ethically – that is, have not acted according to obligations, rules or principles – might have had good, perhaps virtuous, moral reasons for so doing. On this view, in contrast to obligation-based ethics virtue ethics should be considered less uncompromising and more just in terms of attributing blame.

**Patients with chronic illness and the virtues**

It should be clear that the virtue-based approach focuses on the development and sustenance of a virtue-based helping relationship between nurse and patient. While a nurse can exercise the virtues in any nursing speciality, the development of such a relationship is facilitated over a period of time. Some of the examples in this thesis include patients with chronic illness such as arthritis. Patients with chronic illness such as arthritis, diabetes, asthma and manic depression exploit the true nature of the virtues, provide ideal

opportunities for the virtuous activity of nurses and facilitate the development of a virtue-based helping relationship.

It is sensible to suppose that different nursing environments will have an effect on the opportunity and possibility for such a virtuous relationship to be formed in the first place. This goal might not be as achievable in nursing environments where patients are admitted and discharged rapidly. Examples of this include day case surgical wards and outpatient appointments. However, it remains important for nurses to exercise the virtues irrespective of the environment. It is hard to imagine that acting kindly, patiently and justly could ever be seen as examples of acting badly.

It would be interesting to examine the role of nurses working in A&E and identify which virtues are deemed important. Community nursing is an environment where the virtue-based approach would be most profitable.[7] And it would be profitable to investigate the virtue of compassion in terminal care, the role of courage and respectfulness in being an advocate for a patient and the nature of justice as a virtue in issues of resource allocation. These topics could be examined by utilizing a two-pronged approach, namely philosophical enquiry and empirical nursing research.

**Merits of the virtue-based approach in nursing practice**

I examined the merits of the virtue-based approach in nursing practice in Chapter 7 and these were again highlighted in the 'Summary' section at the beginning of this Chapter. In this section, I shall list the merits and then focus on the virtue-based approach and moral dilemmas/moral remainder, Hursthouse on 'morally right decision/right moral decision' and moral education.

The merits of the virtue-based approach in nursing practice include: (a) nurses in their clinical work utilize the language of the virtues and vices, thus a plausible and adequate nursing ethics should acknowledge this; (b) the important role assigned to consequences and outcomes in the moral life is recognized, but there is also a focus upon the role played by emotion in the moral life of patients and nurses; (c) reasons for action are identified and examined in terms of the virtues and vices, for example, has someone acted well or badly?; (d) the patient's lived experience of illness is told in the form of a narrative to a nurse who wants to understand how the illness affects the patient's activities of living; (e) patient-centred and collaborative care is facilitated by the aims and concerns of the virtue-based approach; (f) moral dilemmas are not assumed to be resolvable, the notion of 'right action' is not emphasized, but moral remainder is; and (g) the subject of moral education is held to be of central importance in morality.

I shall discuss (f) and (g) in more detail.

**The virtue-based approach and Hursthouse on dilemmas and moral remainder**

Nurses who cultivate the virtues and develop an understanding of virtue ethics and the virtue-based approach will be aware that moral dilemmas in nursing are either (a) resolvable or (b) irresolvable. But in both kinds of dilemma, nurses will feel moral remainder – negative emotions such as regret, anguish, guilt, hurt, loss, despair and remorse. Nurses should realize that it is a sign of a virtuous moral character to feel these emotions. It is morally appropriate to feel these emotions because the virtuous nurse is fully aware of the distressing nature of nursing situations that for both patient and nurses are saturated with moral tensions, uncertainties and perplexing issues. Moral remainder will be experienced during and after many different nursing interventions/interactions.

Irresolvable dilemmas present when two virtuous persons (nurses) do not know what to do. In the end, both virtuous persons do different things; these situations might involve a conflict between virtues. Despite each act being an example of virtuous behaviour – for example, one is just, another kind – each nurse feels moral remainder. This is intensified because each virtuous nurse evaluates his or her behaviour as less than admirable and far from morally good. On Hursthouse's view both nurses' lives will be marred.[8]

**Hursthouse on 'morally right decision/right moral decision'**

Obligation-based ethics encourages the conflation of two different meanings that can be given to 'morally right decision/right moral decision'. Assume that in a moral dilemma the options are *x* (to coerce a patient to have ECT) and *y* (to respect the patient's wish to refuse ECT). *X* is the better option because it is believed that ECT will help to alleviate the patient's depression, *x* is more beneficial than *y* therefore *x* is carried out.

Other examples of this sort of dilemma (though they might not be seen as such) include whether to sedate a patient against his will, whether to detain someone involuntarily and whether to respect a patient's decision to refuse life-prolonging chemotherapy. These are examples of 'Dynamic' ethical issues that have caught the public attention partly through intensive media attention. But as noted in a recent Delphi study[9] other examples abound in nursing. For example, should a nurse allow a patient to leave the ward for an hour and should a patient be allowed extra pocket money?

Returning to the case in point. Here, the decision to go ahead with the ECT is the 'right moral decision', because it is made on the grounds that *y* was more harmful. But a different use of this phrase refers to a person doing a morally good deed, one that is motivated from the virtues and deserves admiration and praise. Option *x* (coercing a

patient into having ECT), while the morally right option of the two is clearly not an admirable act. Coercing a patient to have a treatment that she would rather not have is not an example of a morally good deed and does not deserve praise or admiration from others.

**Teaching the virtues**

In Chapter 7, it was noted how virtue ethics views the moral education of the young to be crucial to a plausible account of the moral life. I shall consider this in the context of nursing practice.

There appears to be a neglect of the virtues and virtue ethics in the teaching of nursing ethics to pre-registration nurses. This belief was supported by the findings of one small scale Delphi questionnaire study,[10] which showed that 4 out of 11 lecturers from selected departments of nursing in the UK taught virtue ethics to pre-registration student nurses. The focus was instead on consequentialism and deontology, which were taught by 10 out of 11 lecturers. If these findings are supported on a wider scale, then many students will not come into contact with the notions of the virtues and virtue ethics and obligation-based ethics might be seen as the *only* moral approach to nursing practice.

In my recent experience, teaching ethics to common foundation programme (CFP) and adult branch pre-registration nursing students, the majority of students had never heard of the phrase 'the virtues'. However, further discussion revealed that the students were familiar with traits such as 'patience', 'justice' and 'honesty' and they understood how exercising these traits were crucial to being a 'good' nurse.[11] Students rely on lectures and seminars to provide them with an essential knowledge base. But in the Delphi study just

noted, no specialist lecturers in ethics were employed to teach ethics to students of nursing. This might help to explain the lack of focus on the virtues and virtue ethics.

#### Can the virtues be taught?

It was noted in Chapter 3 that in ancient Greece virtue was understood to be a form of knowledge. Typically, knowledge is something that can be taught. Lutzen and Barbosa da Silva claim that the "virtues can be learned by anyone".[12] However, one might argue that the virtues cannot be taught. One might believe that one is either born 'good or bad' and that is how people remain. For example, one who in the past has been a nasty or vicious person (or even someone who has just not been morally good) cannot change and become a morally good person. Or, perhaps while character change on a major scale is impossible, more 'minor' changes are possible such as improving one's self-control. Character change, whether major or minor, is not a process that can happen overnight. It will take a lot of hard work for someone to change character; indeed, changing one's character is probably one of the hardest things a person will ever do.

#### How can the virtues be taught?

In ethics education, it is common to deliver a series of 'key' lectures followed by smaller group work, for example, seminars or tutorials. The virtues, virtue ethics and the virtue-based approach in nursing practice could be taught in the same manner. Discussion and debate could centre on the nature of virtues, the role of virtues in nursing practice and an examination of some of the merits and problems with the virtue-based approach. Differences between the virtue-based and the deontic approaches could be examined and even novice student nurses could begin to think seriously about the role of the virtues and vices in nursing and how interpersonal responses can help or hinder patients to survive illness and recover and fare well beyond illness.

Second, the virtues are best demonstrated in the clinical environment, where learners can observe experienced nurses carrying out their roles in a morally (and clinically) excellent manner. However, there is the question of who should judge moral excellence in nurses? This is more problematic than identifying nurses who are thought to be clinically excellent – the latter can be observed and evaluated by using quantitative methods. It is more difficult, though not impossible, to evaluate a nurse's moral goodness. Despite this obstacle, the notion of good, positive role models runs deep in contemporary culture generally and specifically, in nursing education.[13] The emphasis on the value of mentorship in contemporary nursing practice is related to a feature of virtue ethics mentioned earlier, namely that in a quandary it can be invaluable to ask a wise person for moral guidance. In my nursing experience, it was common for one nurse to ask another, perhaps more experienced nurse, for guidance. Indeed, asking colleagues for guidance and advice is believed by at least some nurses to be a sign of a good team member.

Once role models have been identified, the hard work can begin. Although difficult, inculcating the virtues is possible; note that Aristotle believed that virtuous behaviour resulted from habit.

## Conclusions

I believe that due to the nature and effects of illness, the emphasis in nursing practice should be on the ill patient and the character traits of the nurse who is caring for the patient. It is therefore perplexing that act-centred obligation-based moral theories remain so popular and widespread in nursing practice and nurse education.

I have examined the flaws in obligation-based moral theories and concluded that these theories are incomplete and inadequate moral theories. I have characterized a virtue-

based helping relationship and the virtue-based approach to moral decision-making. The latter focuses on several features that obligation-based ethics neglect. These are: (1) exercising the virtues, (2) using judgment and (3) using moral wisdom. These features enable morally good decisions to be made; such decisions are contextualized and particular.

The cultivation and exercise of moral virtues is of fundamental importance to the end of being a morally good nurse. The practice of nursing can be sustained if nurses exercise the virtues and achieve the internal goods of nursing. If the virtues such as justice are seen in terms of moral principles, then I fear that the virtues will become marginalized.

Exercising the virtues does not go unrecognized by patients. For example, a nurse who acts kindly, a nurse who is gentle and patient and a nurse who is courageous will be held in great esteem and will be praised and admired by both patients and other nurses.

Ethicists, educators and clinical nurses should take virtue ethics and the virtue-based approach to nursing practice more seriously. Naturally, like other moral theories such as consequentialism and deontology, the virtue-based approach can be critiqued. But despite these objections, a strong virtue-ethics/virtue-based approach provides a philosophically adequate and sufficient nursing ethics. As such, it demands one's attention and further investigation.

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[5] Hursthouse, *On Virtue Ethics*, 1999.

[6] A., E. Armstrong, S. Parsons, and P., J. Barker, "An inquiry into moral virtues, especially compassion, in psychiatric nurses: findings from a Delphi Study", *Journal of Psychiatric and Mental Health Nursing* , 2000, **7** , pp. 297-306, p. 300.

[7] Government policies emphasise care of the mentally ill in the community, as noted in G., Sherherd, M. Muijen, T., R. Hadley and H. Goldman, "Effects of mental health services reform on clinical practice in the United Kingdom", *Psychiatric Services* 1996, **47** (12), pp. 1351-1355.

[8] Hursthouse mentions a third possibility, which she calls 'tragic dilemmas'. These are irresolvable dilemmas, wherein something really horrible happens, for instance, a person dies, and generally one or more of people do not emerge.

[9] See: Armstrong, Parsons, and Barker, Unpublished research findings, Moral reasoning in nurses, University of Newcastle upon Tyne, 1999.

[10] S. Parsons, P., J. Barker, and A., E. Armstrong, "The Teaching of Health Care Ethics to Students of Nursing in the UK: A Pilot Study" *Nursing Ethics*, 2001, **8** (1), pp.45-56, pp. 49-50.

[11] Unpublished teaching observation. From 120 CFP students, 75% believed these traits, which they volunteered to me in the lecture, were very important to being a good nurse. Although, not well versed in the technical language of ethics and virtue ethics, these students understood the reality of these traits and their importance in nursing practice (and this was still only 10 months into their nurse education).

[12] K. Lutzen and A. Barbosa da Silva, "The role of virtue ethics in psychiatric nursing" *Nursing Ethics* ,1996, **3** (3), pp. 202-211, p. 209.

[13] See: Lutzen and Barbosa da Silva, "The role of virtue ethics in psychiatric nursing", 1996.

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