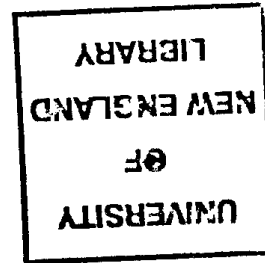


# Principles of Biomedical Ethics

SEVENTH EDITION

**Tom L. Beauchamp**  
Georgetown University

**James F. Childress**  
University of Virginia



New York      Oxford  
Oxford University Press

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

Not only is such a person's character morally incomplete, but also it is morally incoherent in that he or she performs morally right actions for reasons or feelings disconnected from moral motivation. A philanthropist's gift of a new wing of a hospital will be recognized by hospital officials and by the general public as a generous gift, but if the philanthropist only feels the need for public praise and only makes the gift to gain such praise, there is a discordance between those feelings and the performance of the praised action. Feelings and a certain type of motivation are morally important in a virtue theory in a way that can be lost or obscured in an obligation-based theory.<sup>7</sup> Furthermore, there is an important distinction between the *virtuous person* as one whose character reliably leads to action motivated by morally admirable motives and a *virtuous action* as one performed in character by such a person.

## VIRTUES IN PROFESSIONAL ROLES

Persons differ in the particular sets of character traits they possess. Most individuals have some virtues and some vices while lacking other virtues and vices. However, all persons with normal moral capacities can cultivate the character traits of chief importance to morality. In professional life the traits that warrant encouragement and admiration often derive from role responsibilities. Certain virtues are essential to the discharge of these professional roles, and certain vices are intolerable in professional life. Accordingly, we begin with virtues that are critically important in professional and institutional roles and practices in biomedical fields.

### Virtues in Roles and Practices

Professional roles are usually tied to institutional expectations and standards of professional practice. Roles internalize conventions, customs, and procedures of teaching, nursing, doctoring, and the like. Professional practice has a tradition that requires professionals to cultivate certain virtues. Standards of virtue incorporate criteria of professional merit, and possession of these virtues disposes a person to act in accordance with the objectives of the practices.

Consider, for example, professional roles in the practice of medicine. Several goods are internal to the profession and are naturally associated with the idea of being a good physician. These include specific moral and nonmoral skills in the care of patients, the application of specific forms of knowledge, and the teaching of health behaviors. These goods are achievable if, and only if, one abides by the standards of the good physician, standards that have a history and

that in part define the practice. A practice is not merely a set of technical skills. Practices should be understood in terms of the regard practitioners have for the goods internal to the practices. Although these practices are not immune to revision, historical development of a body of standards is definitive of the idea of medicine and nursing as practices.<sup>8</sup>

Roles and practices in medicine and nursing reflect social expectations as well as standards and ideals internal to these professions. Their traditional virtues derive primarily from experience with health care relationships.<sup>9</sup> The virtues we highlight are care—a fundamental virtue for traditional health care relationships—along with five focal virtues: compassion, discernment, trustworthiness, integrity, and conscientiousness, all of which support and promote caring and caregiving. Elsewhere in this chapter and in later chapters, we discuss other virtues, including respectfulness, nonmalevolence, benevolence, justice, truthfulness, and faithfulness.

To illustrate the difference between standards of moral character in a profession (and corresponding moral skills) and standards of technical performance in a profession (and corresponding technical skills), we begin with an instructive study of surgical error. Charles L. Bosk's influential *Forgive and Remember: Managing Medical Failure* presents an ethnographic study of the way two surgical services in "Pacific Hospital" handle medical failure, especially failures by surgical residents.<sup>10</sup> Bosk found that both surgical services distinguish, at least implicitly, between several different forms of error or mistake. The first is *technical*: The professional discharges role responsibilities conscientiously, but his or her technical training or information falls short of what the task requires. Every surgeon will occasionally make this sort of mistake. The second sort of error is *judgmental*: A conscientious professional develops and follows an incorrect strategy. These errors are also to be expected. Attending surgeons forgive momentary technical and judgmental errors but remember them in case a pattern develops indicating that a surgical resident lacks the technical and judgmental skills to be a competent surgeon. The third sort of error is *normative*: A physician violates a norm of conduct or fails to possess a moral skill, particularly by failing to discharge moral obligations conscientiously or by failing to acquire and exercise critical moral virtues such as conscientiousness. Bosk concludes that surgeons view technical and judgmental errors as less important than moral errors, because every conscientious person can be expected to make "honest errors" or "good faith errors." However, moral errors such as failures of conscientiousness are considered profoundly serious when a pattern indicates a defect of character.

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

## Virtues in Alternative Professional Models

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

Thomas Percival's classic 1803 book, *Medical Ethics*, is an example of an attempt to establish the proper set of virtues in medicine. Starting from the assumption that the patient's best medical interest is the proper goal of medicine, Percival reached conclusions about the good physician's traits of character, which were invariably tied to responsibility for the patient's medical welfare.<sup>11</sup> Not surprisingly, this model supported medical paternalism with effectively no attention paid to respect for patients' autonomous choices.

Likewise, in traditional nursing, where the nurse was often viewed as the "handmaiden" of the physician, the nurse was counseled to cultivate the passive virtues of obedience and submission. In contemporary models in nursing, however, active virtues have become more prominent. For example, when the nurse's role is viewed as one of advocacy for patients, prominent virtues include respectfulness, considerateness, justice, persistence, and courage.<sup>12</sup> Attention to patients' rights and preservation of the nurse's integrity have become increasingly prominent in some contemporary models.

The conditions under which virtues are present in morally unworthy and condemnable actions present thorny ethical issues. Virtues such as loyalty, courage, generosity, kindness, respectfulness, and benevolence at times lead persons to act inappropriately and unacceptably. For instance, the physician who acts kindly and loyally by not reporting the incompetence of a fellow physician acts unethically. Such a failure to report professional misconduct does not suggest that loyalty and kindness are not virtues, only that the virtues need to be accompanied by an understanding of what is right and good, and of what deserves loyalty, kindness, generosity, and the like.

## THE VIRTUE OF CARING

As the language of *health care*, *medical care*, and *nursing care* suggests, the virtue of care, or caring, is prominent in professional ethics in these contexts. We treat this virtue as fundamental in relationships, practices, and actions in health

care. In explicating this virtue, or perhaps family of virtues, we draw on what has been called the *ethics of care*, which we interpret as a form of virtue ethics.<sup>13</sup> The ethics of care emphasizes traits valued in intimate personal relationships such as sympathy, compassion, fidelity, and love. *Caring*, in particular, refers to care for, emotional commitment to, and willingness to act on behalf of persons with whom one has a significant relationship. *Caring for* is expressed in actions of “caregiving,” “taking care of,” and “due care.” The nurse’s or physician’s trustworthiness and quality of care and sensitivity in the face of patients’ problems, needs, and vulnerabilities are integral to their professional moral lives.

The ethics of care emphasizes not only what physicians and nurses do—for example, whether they break or maintain confidentiality—but also how they perform those actions, which motives and feelings underlie them, and whether their actions promote or thwart positive relationships. To take an example discussed in a later chapter, a caring clinician considers both whether to disclose the prognosis of a patient’s death (in a few months) and how, when, and where to divulge that prognosis.

### The Origins of the Ethics of Care

The ethics of care, interpreted as a form of philosophical ethics, originated primarily in feminist writings. The earliest works emphasized how women display an ethic of care, by contrast to men, who predominantly exhibit an ethic of rights and obligations. Psychologist Carol Gilligan advanced the influential hypothesis that “women speak in a different voice”—a voice that traditional ethical theory drowned out. She discovered “the voice of care” through empirical research involving interviews with girls and women. This voice, she said, stresses empathic association with others, not based on “the primacy and universality of individual rights, but rather on... a very strong sense of being responsible.”<sup>14</sup>

Gilligan identified two modes of moral thinking: an ethic of care and an ethic of rights and justice. She did not claim that these two modes of thinking strictly correlate with gender or that all women or all men speak in the same moral voice.<sup>15</sup> She maintained only that men tend to embrace an ethic of rights and justice that uses quasi-legal terminology and impartial principles, accompanied by dispassionate balancing and conflict resolution, whereas women tend to affirm an ethic of care that centers on responsiveness in an interconnected network of needs, care, and prevention of harm. The core notion in an ethics of care, then, is caring for and taking care of others.<sup>16</sup>

### Criticisms of Traditional Theories by Proponents of an Ethics of Care

Proponents of the care perspective often criticize traditional ethical theories that seem to de-emphasize virtues of caring. Two criticisms merit consideration here.<sup>17</sup>

*Challenging impartiality.* According to some representations of the care perspective, theories of norms of obligation unduly telescope morality by overemphasizing detached fairness. This orientation is suitable for some moral relationships, especially those in which persons interact as equals in a public context of impersonal justice and institutional constraints, but moral detachment may also evince a lack of caring responsiveness. In the extreme case, detachment becomes uncaring indifference. Lost in the *detachment* of impartiality is an *attachment* to what we care about most and is closest to us—for example, our loyalty to family, friends, and groups. In the absence of public and institutional constraints, partiality toward others is morally permissible and is the expected form of interaction. It is also a feature of the human condition that cannot be eliminated. Without exhibiting partiality, we would impair or sever our most important relationships.<sup>18</sup>

Proponents of care ethics do not recommend a general abandonment of principles as long as principles allow room for discretionary and contextual judgment. At the same time, like many other proponents of virtue ethics, defenders of the ethics of care often find principles irrelevant, unproductive, ineffectual, or unduly constrictive in the moral life. A defender of principles could say that principles of care, compassion, and kindness tutor our responses in caring, compassionate, and kind ways. But this effort to rescue principles seems empty. Moral experience suggests that we often do rely on our emotions, our capacity for sympathy, our sense of friendship, and our sensitivity to determine appropriate moral responses. We can produce rough generalizations about how caring clinicians should respond to patients, but these generalizations cannot provide adequate guidance for all interactions with patients. Each situation calls for a set of responses beyond generalizations, and actions that are caring in one context may be offensive or even harmful in another.

*Relationship and emotion.* The ethics of care places special emphasis on mutual interdependence and emotional responsiveness. Many human relationships in health care and research involve persons who are vulnerable, dependent, ill, and frail. Feeling for and being immersed in the other person are vital aspects of a moral relationship with them.<sup>19</sup> A rights-based or obligation-based account may neglect appropriate forms of empathy because of its focus on protecting persons from wrongdoing by others. Having a certain emotional attitude and expressing the appropriate emotion in action are morally relevant factors, just as having appropriate motives is morally relevant. A person seems morally deficient who acts according to norms of obligation without appropriately aligned feelings, such as concern and sympathy for a suffering person. Good health care often involves insight into the needs of patients and considerate attentiveness to their circumstances, which may derive more from emotional or sympathetic responsiveness than from reason.<sup>20</sup>

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

One proponent of the ethics of care argues that, in a defensible ethical theory, action is sometimes principle-guided, but not necessarily always governed by or derived from principles.<sup>21</sup> This statement moves in the right direction for a comprehensive framework. We need not reject principles of obligation in favor of the virtues of caring, and we can conceive moral judgment as involving moral skills beyond those of specifying and balancing general principles. An ethic that emphasizes the virtues of caring can serve health care well because it is close to the relationships and processes of decision making found in clinical contexts, gives insight into basic commitments of caring and caretaking, and liberates health professionals from narrow conceptions of role responsibilities often found in professional codes of ethics.

## FIVE FOCAL VIRTUES

We now examine five focal virtues for health professionals: compassion, discernment, trustworthiness, integrity, and conscientiousness. These virtues are important in part for the development and expression of caring, which we have presented as the fundamental orienting virtue in health care. These virtues provide a moral compass of character for health professionals, and some have played a prominent role for centuries in the ethics of physicians.<sup>22</sup> Other virtues are no less important, and we treat several of them later and in Chapter 9.

### Compassion

Compassion is a "prelude to caring."<sup>23</sup> The virtue of compassion combines an attitude of active regard for another's welfare with an imaginative awareness and emotional response of sympathy, tenderness, and discomfort at another's misfortune or suffering.<sup>24</sup> Compassion presupposes sympathy, has affinities with mercy, and is expressed in acts of beneficence that attempt to alleviate the misfortune or suffering of another person. Unlike the virtue of integrity, which is focused on the self, compassion is directed at others.

Nurses and physicians must understand the feelings and experiences of patients to respond appropriately to them and their illnesses and injuries—hence the importance of empathy, which involves the reconstructing of another person’s mental experience, whether that experience is negative or positive.<sup>25</sup> As important as empathy is for compassion and other virtues, the two are different and empathy does not always lead to compassion. Literature on professionalism in medicine and health care now often focuses on empathy rather than compassion. This literature may be making the mistake of viewing empathy alone as sufficient for humanizing medicine and health care.<sup>26</sup>

Compassion generally focuses on others’ pain, suffering, disability, and misery—the typical occasions for compassionate responses in health care. Using the language of *sympathy*, eighteenth-century philosopher David Hume pointed to a typical circumstance of compassion in surgery and explained how it arises:

Were I present at any of the more terrible operations of surgery, ‘tis certain, that even before it begun, the preparation of the instruments, the laying of the bandages in order, the heating of the irons, with all the signs of anxiety and concern in the patient and assistants, wou’d have a great effect upon my mind, and excite the strongest sentiments of pity and terror. No passion of another discovers itself immediately to the mind. We are only sensible of its causes or effects. From *these* we infer the passion: And consequently *these* give rise to our sympathy.<sup>27</sup>

Those physicians and nurses who express no compassion in their behavior fail to provide what patients need most. The physician or nurse lacking altogether in the appropriate display of compassion has a moral weakness. However, compassion also may cloud judgment and preclude rational and effective responses. In one reported case, a long-alienated son wanted to continue a futile and painful treatment for his near-comatose father in an intensive care unit (ICU) to have time to “make his peace” with his father. Although the son understood that his alienated father had no cognitive capacity, the son wanted to work through his sense of regret. Some hospital staff argued that the patient’s grim prognosis and pain, combined with the needs of others waiting to receive care in the ICU, justified stopping the treatment, as had been requested by the patient’s close cousin and informal guardian. Another group in the unit regarded continued treatment as an appropriate act of compassion toward the son, who they thought should have time to express his farewells and regrets to make himself feel better about his father’s death. The first group, by contrast, viewed compassion as misplaced because of the patient’s prolonged agony and dying. In effect, those in the first group believed that the second group’s compassion prevented clear thinking about primary obligations to this patient.<sup>28</sup>

Many writers in the history of ethical theory have proposed a cautious approach to compassion. They maintain that a passionate, or even a compassionate, engagement with others can blind reason and prevent impartial reflection.

Health care professionals understand and appreciate this phenomenon. Constant contact with suffering can overwhelm and even paralyze a compassionate physician or nurse. Impartial judgment can give way to impassioned decisions, and emotional burnout can occur. To counteract this problem, medical education and nursing education are designed to inculcate detachment alongside compassion. The language of *detached concern* and *compassionate detachment* appropriately appears in health care ethics expressly to identify a complex characteristic of the good physician or good nurse.

### Discernment

The virtue of discernment brings sensitive insight, astute judgment, and understanding to bear on action. Discernment involves the ability to make fitting judgments and reach decisions without being unduly influenced by extraneous considerations, fears, personal attachments, and the like. Some writers closely associate discernment with practical wisdom, or *phronesis*, to use Aristotle's term. A person of practical wisdom knows which ends to choose, knows how to realize them in particular circumstances, and carefully selects from among the range of possible actions, while keeping emotions within proper bounds. In Aristotle's model, the practically wise person understands how to act with the right intensity of feeling, in just the right way, at just the right time, with a proper balance of reason and desire.<sup>29</sup>

The person of discernment is disposed to understand and perceive what circumstances demand in the way of human responsiveness. For example, a discerning physician will see when a despairing patient needs comfort rather than privacy, and vice versa. If comfort is the right choice, the discerning physician will find the right type and level of consolation to be helpful rather than intrusive. If a rule guides action in a particular case, seeing *how* to follow the rule involves a form of discernment that is independent of seeing *that* the rule applies.

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

### Trustworthiness

Virtues, Annette Baier maintains, "are personal traits that contribute to a good climate of trust between people, when trust is taken to be acceptance of being, to some degree and in some respects, in another's power."<sup>30</sup> This climate of trust is essential in medical and health care, where patients are vulnerable and must put themselves in the hands of health care professionals. Trust is a confident belief in and reliance on the moral character and competence of another person, often

a person with whom one has an intimate or established relationship. Trust entails a confidence that another will reliably act with the right motives and feelings and in accordance with appropriate moral norms.<sup>31</sup> To be *trustworthy* is to merit confidence in one's character and conduct. Trustworthiness has the practical outcome of making health care effective. Nothing is more important in health care organizations than the maintenance of a culture of trust.

Traditional ethical theories rarely mention either trust or trustworthiness. However, Aristotle took note of one aspect of trust and trustworthiness. He maintained that when relationships are voluntary and among intimates, in contrast to legal relationships among strangers, it is appropriate for the law to forbid lawsuits for harms that occur. Aristotle reasoned that in intimate relationships "dealings with one another as good and trustworthy," rather than "bonds of justice," hold persons together.<sup>32</sup>

A true climate of trust is endangered in contemporary health care institutions, as is evidenced by the number of medical malpractice suits and adversarial relations between health care professionals and the public. Overt distrust has been engendered by mechanisms of managed care, because of the incentives some health care organizations create for physicians to limit the amount and kinds of care they provide to patients. Appeals have increased for ombudsmen, patient advocates, legally binding "directives" to physicians, and the like. Among the contributing causes of the erosion of a climate of trust are the loss of intimate contact between physicians and patients, the increased use of specialists, and the growth of large, impersonal, and bureaucratic medical institutions.<sup>33</sup>

## Integrity

Some writers in bioethics claim that the primary virtue in health care is integrity.<sup>34</sup> People often justify their actions or refusals to act on grounds that they would otherwise compromise or sacrifice their integrity. Later in this chapter we discuss these appeals to integrity as invocations of *conscience*, but we confine attention here to the virtue of integrity.

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

among a person's moral convictions, emotions, and actions. The most common deficiency is probably the simple lack of sincerely and firmly held moral convictions; but no less important is the failure to act on the correct moral beliefs that one does hold.

Problems in maintaining integrity arise not only from a lack of moral conviction or a conflict of moral norms, but also from moral demands that require persons to sacrifice in a way that causes them to abandon their personal goals and projects. Persons can feel violated by having to abandon their personal commitments to pursue moral objectives. For example, if a nurse is the only person in her family who can properly manage her mother's health, health care, prescription medications, nursing home arrangements, explanations to relatives, and negotiations with physicians, little time may be left for her personal projects and commitments. Such situations can deprive us of the liberty to structure and integrate our lives as we choose. If a person has structured his or her life around personal goals that are ripped away by the needs and agendas of others, a loss of personal integrity occurs.

*Professional* integrity presents issues about wrongful conduct in professions. Because breaches of professional integrity involve violations of professional standards of conduct, they are often viewed as violations of the rules of professional associations. This vision is too narrow.<sup>35</sup> Breaches of professional integrity also occur when a physician prescribes a drug that is not effective, enters into a sexual relationship with a patient, or follows a living will that asks for a medically outrageous "treatment"—whether or not professional associations disallow such conduct and whether or not the physician feels bound by the standards of conduct.

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

Health care facilities cannot entirely eliminate these and other problems of staff disagreement, but persons with the virtues of patience, humility, and tolerance can help to ameliorate these problems. Situations that compromise integrity can be ameliorated if participants anticipate the problem before it arises and recognize the limits and fallibility of their moral views. Participants in a dispute may also have recourse to consultative institutional processes, such as hospital ethics committees. However, it would be ill-advised to recommend that a person

of integrity can and should always negotiate and compromise his or her values in an intrainstitutional confrontation. There is something ennobling and admirable about the person or organization that refuses to compromise beyond a certain carefully considered moral threshold. To compromise below the threshold of integrity is simply to lose it.

### Conscientiousness

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

*Conscience and conscientiousness.* *Conscience* has often been viewed as a mental faculty of, and authority for, moral decision making.<sup>37</sup> Slogans such as, "Let your conscience be your guide" suggest that conscience is the final authority in moral justification. However, this account fails to capture the nature of either conscience or conscientiousness. We can see why by examining the following case put forward by Bernard Williams: Having recently completed his Ph.D. in chemistry, George has not been able to find a job. His family has suffered from his failure: They are short of money, his wife has had to take additional work, and their small children have been subjected to considerable strain, uncertainty, and instability. An established chemist can get George a position in a laboratory that pursues research in chemical and biological warfare. Despite his perilous financial and familial circumstances, George concludes that he cannot accept this position because of his conscientious opposition to chemical and biological warfare. The senior chemist notes that the research will continue no matter what George decides. Furthermore, if George does not take this position, it will be offered to another young man who would pursue the research vigorously. Indeed, the senior chemist confides, his concern about this other candidate's nationalistic fervor and uncritical zeal for research in chemical and biological warfare motivated him to recommend George for the job. George's wife is puzzled and hurt by George's reaction. She sees nothing wrong with the research. She is profoundly concerned about their children's problems and the instability of their family. Nonetheless, George forgoes this opportunity both to help his family and to prevent a destructive fanatic from obtaining the position because his conscience stands in the way.<sup>38</sup>

Conscience, as this example suggests, is not a special moral faculty or a self-justifying moral authority. It is a form of self-reflection about whether one's acts are obligatory or prohibited, right or wrong, good or bad, virtuous or

vicious. It also involves an internal sanction that comes into play through critical reflection. When individuals recognize their acts as violations of an appropriate standard, this sanction often appears as a bad conscience in the form of feelings of remorse, guilt, shame, disunity, or disharmony. A conscience that sanctions conduct in this way does not signify bad moral character. To the contrary, this experience of conscience is most likely to occur in persons of strong moral character and may even be a necessary condition of morally good character.<sup>39</sup> For example, kidney donors have been known to say, "I had to do it. I couldn't have backed out, not that I had the feeling of being trapped, because the doctors offered to get me out. I just had to do it."<sup>40</sup> Such poignant statements indicate that some ethical standards are sufficiently powerful that violating them would diminish integrity and result in guilt or shame.<sup>41</sup>

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

*Conscientious refusals.* Conscientious objections by physicians, nurses, pharmacists, and other health care professionals raise difficult issues for public policy, professional organizations, and health care institutions. Examples are found in a physician's refusal to honor a patient's valid advance directive to withdraw artificial nutrition and hydration, a nurse's refusal to participate in an abortion or sterilization procedure, and a pharmacist's refusal to fill a prescription for an emergency contraception. There are good reasons to promote conscientiousness and to respect acts of conscience, but some conscientious refusals adversely affect patients' and others' legitimate interests. Public policy, the professions, and institutions should seek to recognize and accommodate conscientious refusals as long as they can do so without seriously compromising patients' rights and interests.

The metaphor of balance, or balancing, is commonly used to guide efforts to protect both interest sets. Accordingly, no single model of appropriate response covers all cases.<sup>42</sup> Frequently, institutions such as hospitals and pharmacies can ensure the timely performance of needed or requested services while allowing particular conscientious objectors not to perform those services.<sup>43</sup> However, ethical complexities arise when, for example, a pharmacist refuses, on grounds of complicity in moral wrongdoing, to refer or transfer a consumer's prescription

or to inform the consumer of pharmacies that would fill the prescription. According to one study, 14% of U.S. physicians surveyed do not feel obligated to disclose information about morally controversial medical procedures, and 29% of U.S. physicians do not recognize an obligation to refer patients for such procedures.<sup>44</sup>

At a minimum, health care professionals have an ethical duty to inform prospective employers and prospective patients, clients, and consumers in advance of their conscientious objections to performing vital services. Likewise, they have an ethical duty to disclose options for obtaining legal, albeit morally controversial, services and, in many cases, a duty to provide a referral for those services. They also have a duty to perform those services in emergency circumstances when the patient is at risk of adverse health effects and a timely referral is not possible.

Determining the appropriate scope of protectable conscientious refusals is a vexing problem that arises, for example, because of conscientious objections to expanded notions of participation in or assistance in the performance of an objectionable action. These expanded notions include actions that are only indirectly related to the objectionable procedure. For example, some nurses have claimed conscientious exemption from all forms of participation in the care of patients having an abortion or sterilization, even to the extent of declining to fill out admission forms or provide postprocedure care. It is difficult in institutions, and less clearly required from an ethical standpoint, to exempt objectors to such broadly delineated forms of participation in a procedure.

## MORAL IDEALS

We argued in Chapter 1 that norms of obligation in the common morality constitute a moral minimum that pertains to everyone. These standards are notably different from extraordinary moral standards, which are neither required nor obligatory. However, general ideals such as extraordinary generosity are rightly admired and endorsed by all morally committed persons, and in this respect they form part of the common morality. Extraordinary moral standards come from a morality of aspiration in which individuals and communities adopt high ideals not demanded of others. We can praise and admire those who fulfill these ideals, but we cannot blame or criticize persons who do not pursue them.

A straightforward example of a moral ideal in biomedical ethics is found in “expanded access” or “compassionate use” programs that authorize access, prior to regulatory approval, to an investigational drug or device for patients with a serious or immediately life-threatening disease or condition. These patients have exhausted available therapeutic options and are situated so that they cannot participate in a clinical trial of a comparable investigational product. Although it is clearly compassionate and justified to provide some investigational products for