

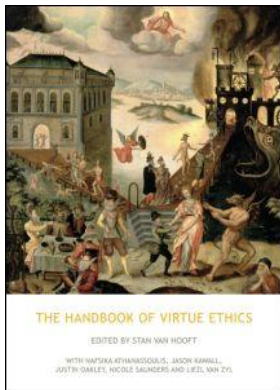
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Publisher: *Routledge*

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The Handbook of Virtue Ethics

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Virtue in the clinic

Publication details

<https://www.routledgehandbooks.com/doi/10.4324/9781315729053.ch29>

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Published online on: 27 Nov 2013

How to cite :- Matthew McCabe. 27 Nov 2013, *Virtue in the clinic from: The Handbook of Virtue Ethics* Routledge

Accessed on: 01 Apr 2023

<https://www.routledgehandbooks.com/doi/10.4324/9781315729053.ch29>

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Applied ethics

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Virtue in the clinic

Matthew McCabe

Through the efforts of many scholars in moral philosophy, moral psychology and education, the ethics of care has emerged as a legitimate ethical approach capable of standing on its own as an alternative to the more traditional deontological and consequentialist views. At least one construal of the ethics of care casts itself as a form of virtue ethics with the motive of care or concern for others being the primary virtue to serve as the basis of moral judgement. While much of the recent literature has been directed at developing and defending the content of the approach itself, some work has been dedicated to exploring the application of the ethics of care to professional ethical contexts such as medical practice. However, applications of the virtue ethics of care to issues in biomedical ethics remain largely unexplored and it is my intention to offer some insights into what this perspective might say on a few of the many substantive moral issues in medical practice. Traditionally, the physician–patient relationship itself and most of the main issues surrounding it have been discussed in the context of deontological or consequentialist perspectives. One challenge for any formulation of virtue ethics is to recast the relationship and the issues in aretaic terms.

I will begin by describing the main features of the virtue ethics of care and explain the ways in which they stand out in the health care context. Here I will also note some of the contributions made in this area by myself and others. Next, I will spend a good amount of time exploring a less discussed area of biomedical ethics: the ethical responsibilities of being a patient.¹ Operating from a significantly different point of view, it will be insightful to bring to light the sorts of patient behaviours that ethical caring will find to be admirable or insensitive as well as the responsibilities one takes on when assuming the role of “patient”. I will then offer a virtue ethics of care representation of three major issues in medical practice; physician–patient confidentiality, end-of-life decision-making and actions, and beginning-of-life decisions. In each context, I will attempt to illustrate the ways in which the virtue ethics of care perspective differs from traditional deontological and consequentialist views on the subject. I will conclude by offering some suggestions

on the direction the virtue ethics of care should go in order to secure a rightful “seat at the bioethics table”.

THE VIRTUE ETHICS OF CARE IN MEDICAL PRACTICE

As I mentioned above, the virtue ethics of care takes the motive of care or concern for others – specifically, how actions reflect such motives – as the foundation of moral judgment. This is a robust notion of ethical concern with three primary features: empathetic understanding, sensitivity to context, and balanced care.

Empathetic understanding is achieved when the moral agent makes a genuine effort to come to understand the perspective of the recipients of his caring efforts. Through this process, optimally done through open and honest two-way dialogue, the moral agent also develops and fosters a desire to serve the needs of the cared-for through action. One often expressed need of patients is to have their autonomy respected when making decisions about medical treatment. Historically, respect for autonomy has been described and justified in deontic terms. However, it is instructive to talk about its place within a virtue ethics of care framework.² I have suggested that autonomy can be understood in purely aretaic terms if we regard it as an important aspect of human welfare and a critical part of caring relationships. From the virtue ethics of care perspective, “autonomy becomes something not merely to be respected or honored but rather an element of human welfare and relationships to be nurtured, restored, or empowered” (McCabe 2008: 274). An obvious way in which an ethically caring physician can empower an autonomous patient is by providing him with as much medically relevant information as possible about his case in a manner that he can understand and use to make a treatment decision.

Sensitivity to context occurs when the moral agent formulates plans of action on behalf of the cared-for by considering contextual details surrounding the particular situation and the particular person involved. Among the details to consider are the various relationships the caring agent stands in with the objects of her concern. This includes the rather general relationship one has with fellow human beings as well as specific professional or role-defined relationships. The role of a health care professional, such as a physician, carries with it a number of important socially generated expectations that any agent must care about. I have suggested elsewhere (*ibid.*: 275) that the role of a physician can be understood in terms of what Edmund Pellegrino and David Thomasma call “the ends of medicine”: “Briefly, the ends of medicine are ultimately the restoration and improvement of health and, more importantly, to heal, that is to cure illness and disease or, when this is not possible, to care for and help the patient to live with residual pain, discomfort, or disability” (Pellegrino & Thomasma 1993: 52–3). These ends generate a number of expectations and responsibilities that an ethically caring physician must thoughtfully consider when interacting with patients. I will discuss confidentiality shortly, but other examples include respect for autonomy, honesty and patient advocacy.

Sensitivity to context also requires that a caring agent maintain an awareness of his or her own talents, abilities and limitations, and how they bear on the situation surrounding the object of care at that particular time. For example, a surgeon who has only performed a highly risky procedure once on a cadaver should give such a limitation serious consideration before attempting to perform it on a living patient.

One noteworthy repercussion of sensitivity to context is that the virtue ethics of care is not going to take a rigid stand on any general action or practice (examples in medical practice would include dishonesty, abortion and active euthanasia). Instead, there will be a willingness to consider exceptions to any general rule as long as they reflect a caring motive shaped by sensitivity to special contextual details.

The final feature of the caring motive, balanced care, is reached when the moral agent balances her efforts and resources among three general classes: intimate or partialistic concern for those near and more proximate, humanitarian concern for those distant or with little or no connection or history with the physician, and special concern for oneself. A physician will naturally have her current patients foremost in her mind. But that does not mean that she may ignore prospective patients (or patients of a particular race, gender, age, etc.). She must also balance concern for her patients with the larger issues surrounding medical practice, such as the costs of patient care to the system as a whole. Finally, narrowly and broadly focused concern must be balanced with the concern the physician naturally has for herself. An obvious example is the time a physician wants and needs to spend with her family. Another, perhaps more complicated, example would be the “down time” she must take in order to avoid “professional burnout”.

The virtue ethics of care directs us to develop the ability to assess a motive reflected in action by ascertaining the extent to which it displays empathetic understanding, sensitivity to context and balanced care. The more the motive embodies these three features, the more admirable it is. The more any of these features are absent, the more inclined we will be to judge the motive insensitive, uncaring or deplorable.

THE ETHICS OF BEING A PATIENT

Before moving on to apply the virtue ethics of care to some specific ethical issues in medical practice, I would like to take some time to talk about what the virtue ethics of care would require of patients. Generally speaking, this topic has received much less attention, with much more of the focus centred on health care professionals and what morality requires of them. I think this can be explained by the difference in power and vulnerability between the two: health care professionals are in a much stronger position and would seem to have greater moral responsibilities. Given their weaker position, it may seem a bit harsh to level heavy moral expectations upon patients. But both health care professionals and patients are unified in pursuing the ends of medicine in specific contexts and each can significantly help or hinder the achievement of those ends.

I think that the main care-based moral expectations placed upon patients can be centred upon their contribution to meeting the ends of medicine given their particular situation. Put simply, a patient's motive for action is admirable when it is shaped by being sensitive towards, or concerned about, meeting those ends. The more they contribute in meaningful ways, the more admirable their actions will be. The more they hinder or even undermine the process, the more deplorable their actions become.

There are numerous ways in which a patient can help or hinder achieving the ends of a medical encounter. I will focus on some of the more obvious. A patient arguably serves them best by openly and honestly communicating as much relevant information as possible. Patient dishonesty or nondisclosure of important medical information may

be explained in a number of ways – shame, embarrassment, mistrust and self-deception to name a few – but such actions are still not admirable because they reflect a motive that is insensitive towards meeting the ends of the clinical encounter.

One important part of open and honest communication involves expressing to the physician how much of a role the patient wishes to take in treatment decision-making. If a patient wishes to have her autonomy respected and to be an active member of the medical decision-making process, certain actions will reflect a more admirable, caring motive. Examples would include asking relevant questions regarding treatment options and outcomes, seeking clarification of important but complex medical information, and ultimately selecting a treatment option while being prepared to articulate a rationale for such a selection and an acknowledgement of the anticipated outcomes, good or bad. Failure to take seriously the role one takes on as a medical decision maker, being non-committal, or deciding on a whim with no rationale, will reflect an uncaring and insensitive motive.³

Once a patient has made a decision on a treatment option, she must follow through and commit herself to executing the plan in order to reach the desired medical outcome. Missing scheduled appointments or treatments, falling out of medication schedules, failing to communicate new or changing health conditions are all examples of actions reflecting less than admirable insensitivity to the mutually agreed upon project.

One way in which a patient can be sensitive to serving rather than hindering the medical process and achieving her desired medical outcome is to make every effort to face up to the medical realities surrounding her situation. This is not always easy as the facts about one's health can be hard to accept, and it is tempting to ignore or downplay them. It is worth exploring this issue in some detail as it brings to light another virtue, courage, and provides an example of how it and other virtues can operate under a virtue ethics of care framework.

In *Morals From Motives*, Michael Slote argues that if knowledge is to count as a human good, it will require the virtue of courage. The kind of knowledge that makes one's life happier, better or more content is often the kind that is hard to bear. Slote gives the example of those in the nineteenth century who, finding the scientific discoveries of the time to be quite persuasive, had to courageously abandon the entrenched Biblical accounts of human life and destiny (Slote 2001: 158).

A similar argument can be made about knowledge in the medical context. If a patient's life is to be happier or more content she will need the courage to face up to difficult facts regarding her health condition, for example ovarian cancer, before and after treatment. While not easy to acknowledge, failure to do so will create the risk of making the patient's life worse. Courage provides a means to cope with the medical realities and move forward in a positive direction. Acting courageously also reflects a motive of concern for serving the ends of medicine. Conversely, a person lacking courage in this context displays a less than admirable insensitivity to the physician–patient relationship by sliding into evasiveness, self-deception and other vices.

Other virtues, then, can enter the virtue ethics of care picture in two ways. They can be seen as required elements to securing human goods – as courage acts to secure knowledge – or they can be seen as contributing to the development of a caring motive (or betraying an uncaring motive if they are absent). In the context of medical practice, a number of virtues stand out among physicians and patients, including self-awareness, honesty,

openness and, in the case of patients, courage. I would now like to turn the focus back to physicians and discuss the long-standing issue of patient confidentiality.

CONFIDENTIALITY

As with all of the main features of the physician–patient relationship, confidentiality has most often been described and justified in deontic terms. It can be understood to be associated with a patient’s right to privacy, or as an obligation that a physician is duty bound to honour. An example of this rendering appears in Beauchamp and Childress’s *Principles of Biomedical Ethics*: “Confidentiality is present when one person discloses information to another, ... and the person to whom the information is disclosed pledges not to divulge that information to a third party without the confider’s permission” (Beauchamp & Childress 2009: 304). This important aspect of the relationship can be recast in care-based terms. Put simply, respect for patient confidentiality can be justified by way of a caring motive shaped in no small part by sensitivity to contextual detail.

It could be argued that, given the conditions surrounding the relationship, respect for confidentiality represents the clearest connection to care-based medical practice. In virtually all cases, the patient and physician encounter each other on an unequal footing. The patient, owing to a physical or mental health condition or suspicion of a condition, is generally in a weaker and more vulnerable position than the healthy physician. In addition, the patient (unless she is a health care professional) has a notably inferior knowledge-base with regard to medical science. Finally, the information a patient gives to her physician is frequently of an intimate and deeply personal nature, creating further vulnerability. Yet, as I discussed earlier, a caring patient must present as much medically relevant information as she can, no matter how intimate, embarrassing or disconcerting it is. Any physician who ignores or disregards this general context is already displaying a deplorably insensitive motive.

In addition to this general context, a physician must be concerned about meeting patient expectations with regard to the handling of private information. When a patient shares deeply personal information with a physician, the patient expects it to remain private. She might permit the sharing of relevant information with other health care professionals but only if it serves the objectives of the medical process: the selection and implementation of the best possible treatment. Even if sharing of patient information is permitted, it is still expected that such information will remain confidential among those who receive it.

Such expectations held by patients are generated from two sources. First are the formal and informal oaths taken by a physician. The promise to hold private information in confidence goes as far back as the Hippocratic Oath. Second, the expectation of confidentiality is also derived from an understanding of the conventional role of health care professionals. There is little doubt that respect for patient confidentiality is commonly associated with, or assumed to be associated with, the role of health care professional. Therefore, in taking a professional oath and in assuming the role of physician, one must take the expectations produced seriously and be continually concerned about the harm produced by disappointing such expectations. Failure to do so would reflect an insensitive, uncaring motive.

What is arguably more important than concern over disappointing patient expectations of medical professionals is the concern any person, including a physician, should have

towards another person's privacy. The protection of and respect for intimate details about one's life is a substantive psychological need possessed by most humans. I will not argue here that privacy is an integral part of human welfare but there can be little doubt that it is an important (if not essential) ingredient to the well-being of most people. Even if it is not an essential component of the good life, protecting the intimate, private details of a patient's life must be given due consideration if a physician is to be motivated by and act out of ethical concern for a patient.

Now that confidentiality has been given some justification from the virtue ethics of care perspective, it will be useful to explore the circumstances under which a physician could violate confidentiality in the name of ethical caring. The rare cases where the virtue ethics of care would expect or permit the betrayal of patient confidentiality will most often involve a concern for a third party. The best way to elucidate this point is by examining some cases.

First, I would like to discuss the well-known (in American medical practice) Tarasoff Case (Tarasoff v. Regents of the University of California, 17 Cal. 3d 425 (1976); 131 California Reporter 14, July 1, 1976). For purposes of my discussion I will only focus on the facts in the case and not on the opinions of the California Supreme Court. In October of 1969, Tatiana Tarasoff was murdered. The killer was Prosenjit Poddar. Two months before the crime Poddar made his murderous intentions known to Dr Lawrence Moore, a psychologist employed by the Cowell Memorial Hospital at the University of California at Berkeley. With the agreement of two additional doctors Moore took initial steps to have Poddar committed for observation in a mental hospital. Shortly after taking Poddar into custody, police officers released him believing that he was rational and accepting his promise not to come near Ms Tarasoff. This was followed by an order from the director of the department of psychiatry at Cowell Memorial Hospital to take no action to place Poddar into custody. In the two months following his release, Poddar convinced Ms Tarasoff's brother to share an apartment near her residence with him. Shortly after Ms Tarasoff returned from a trip to Brazil, Poddar went to her residence and killed her. The plaintiffs, the parents of Ms Tarasoff, made the legal accusation that the psychiatry department was negligent in failing to inform their daughter of the danger to her life.

Another case, discussed by Beauchamp and Childress (2009: 307–8), comes from a controversy surrounding the HIV epidemic. The issue has been raised over whether confidentiality should be respected even if it means that spouses or life-partners of infected patients could also become infected. Beauchamp and Childress discuss the case of a physician who informs a bisexual male patient that he has been infected with HIV. After being informed of the risks to his wife and partners, the patient refused to tell them and demanded that the physician maintain absolute confidentiality. The physician complied and, ultimately, the wife became infected as well.⁴

As I mentioned earlier, a notable feature of the virtue ethics of care is its steadfast refusal to view moral tenets as absolute or exceptionless. In both cases above, the contexts are such that breaches of confidentiality would arguably be acceptable. If the three psychologists who originally assessed Poddar's mental dispositions genuinely believed that Ms Tarasoff's life was in danger they could have justifiably disregarded respect for confidentiality and informed her of the danger. Following Poddar's release, the fact that nothing was done by the doctors or the authorities for two months arguably shows a complete lack of concern for the welfare of Ms Tarasoff. The same judgement can be made of the physician's response

to the HIV infected patient. There can be no doubt that the risk of infection and, ultimately, death was quite real for the wife. To ignore such risk in blind deference to patient confidentiality is unethically insensitive to the welfare of a (not terribly) distant other. The fact that she (or Ms Tarasoff) was not a patient does not absolve the doctors of moral responsibility. Recall that the notion of balanced care requires that one not ignore those who may be more distant or less proximate to the primary objects of care. At a minimum, the physician could have continued to engage the patient in conversation and attempt to persuade him to inform his wife. Failing that, informing the wife, while a breach of patient confidentiality, would be clearly acceptable because of the motive for doing so.

To close, it is worth noting that the cases discussed above point to two important factors that must shape the motive of a physician who considers breaching patient confidentiality. First, and most obvious, is a general concern for the welfare of distant others, including those who are not patients. Second, the motive must be shaped by close attention to contextual detail. Specifically, one must do one's best to ascertain the degree of harm to the third party and also the probability of the harm coming to fruition. The more severe the harm and the greater the probability of it occurring, the more inclined a caring physician should be to breach confidentiality.⁵ In the first case, three psychologists were convinced of Poddar's intention to take a human life to the point that they took steps to have him involuntarily committed. In the second case, HIV infection is frequently lethal and, given the patient's history, the risk that the wife would become infected was quite high. Given these details any ethically caring physician with a sense of balancing care among close and distant others must take some action on behalf of the third party. In all likelihood the best action would be to inform them of the danger.

Finally, it is important to identify a safeguard to prevent a slippery slide into morally unacceptable breaches of patient confidentiality in the name of concern for third parties. That safeguard is the concern any physician or health care professional must have towards maintaining an environment of trust. Patient trust is an essential component of the relationship and, if recklessly undermined, this will be detrimental to meeting the ends of medicine. So an ethically caring physician must balance the need to breach a patient's confidences against maintaining an environment of trust in both the narrow context of his patient and the broader context of how patients in general perceive physicians.⁶

END-OF-LIFE DECISIONS

I would now like to move on to the difficult medical context where a patient, suffering from a terminal illness, seeks assistance in dying. Euthanasia has ancient roots, but has grown much more complicated with the continuing development of medical technology. For many years the ethics of euthanasia has been centred on a distinction between two kinds of actions, "killing" or "letting die", that physicians could perform on terminal patients. However, the effort to establish a moral distinction between "killing" and "letting die" has become increasingly problematic over the years. Among the first to challenge the distinction was James Rachels in his essay "Active and Passive Euthanasia". There he put forward a persuasive argument asserting that one's motive for a killing or letting die action is morally significant. He brought the force of this argument to light with the hypothetical cases of Smith and Jones. Both stand to gain large sums of money through inheritance if anything

should happen to their respective cousins. One night, Smith sneaks into the bedroom of his cousin and drowns him in the tub. Jones intended to do the same, but upon entering the bathroom and seeing that his young cousin was already drowning from a slip and fall, stands by and lets nature take its course. The idea that Jones can walk away with his hands clean and free of moral judgement by claiming that he did not kill the boy, but merely let him die, is a “grotesque perversion of moral reasoning” to Rachels (1975: 79).

More recently, Beauchamp and Childress (2009: 176) have argued that the moral distinction suffers so badly from “vagueness and moral confusion” that it should not be used as a basis of judgement in end-of-life cases. In their view, a key point against the distinction lies in its tendency to cover up or impede the consideration of relevant factors that ought to be used to make an informed moral judgement. A central factor to be considered is insight from the patient. For example, did the patient authorize the discontinuation of medical technological assistance, or seek assistance in ending his or her life? (*ibid.*: 175).

I mention these two positions on the moral distinction between killing and letting die because they bring to light how well the virtue ethics of care fits into some compelling moral intuitions on end-of-life situations. Rachels, along with Beauchamp and Childress, argue that what is important to the permissibility of actions to bring about the end of a patient’s life are the motives of the doctor shaped by thoughtful consideration of contextual factors. This is precisely what the virtue ethics of care would require. In order for a physician’s participation in ending the life of a suffering patient to be considered admirable, it would have to reflect a motive of empathetic concern for the patient that was sensitive to the contextual details surrounding the patient’s particular medical situation. An obvious and critical detail that a physician must be concerned about is the patient’s competent request for assistance in dying or authorization to discontinue or forgo medical treatment.

A sense of what drives an admirable, care-based instance of assistance in dying can be made clear through an example. In a now well-known case, Dr Timothy Quill assisted in bringing about the death of Ms Diane Trumbull by prescribing her barbiturates and explaining to her the exact amount that would constitute a lethal dose. When her cancer reached a point where she no longer desired to endure the pain and suffering, she took her own life with the prescribed barbiturates. The process which led to her death was not rushed or reckless. She and Quill had an eight-year relationship as patient and physician. He knew of her medical history and of her “strong sense of independence” (Quill 1993: 10). Upon hearing of the cancer diagnosis and the treatment options, she and Quill engaged in several discussions where each articulated their views. Her first decision was to refuse treatment. In subsequent discussions, she voiced her concern about the pain, suffering and loss of independence she would endure as the cancer progressed. It was so important to her to maintain her sense of independence and her dignity that she declared to Quill that she wished to die when these aspects of her life were lost. Quill proceeded to inform her about the Hemlock Society. Once she obtained information on how to end her life, she contacted Quill and requested a prescription for barbiturates to help her sleep. Knowing of her real plans, Quill wrote the prescription and made sure that she was aware of what would constitute a lethal dose. In order to prevent the possible legal prosecution of Quill and her family, she insisted that she be left alone the morning she took her life (*ibid.*: 11–15).

The actions of Dr Quill reflect an admirable, caring motive in a number of ways. There are at least two ways in which he displayed empathy towards his patient. First, while he did

not agree with her refusal of treatment initially, after continued dialogue with her he came to understand her position and accept it as the right one for her. Second, after hearing of her concerns about suffering and loss of control, he developed the desire to help and directed her to information from the Hemlock Society. These are clear-cut instances of what I called empathetic understanding.

Quill also demonstrated sensitivity to Ms Trumbull's particular situation in several instances. He grounded his decision to assist her on his understanding of her specific medical case history of which he had been a part for eight years. His decision was also based upon his awareness of her strong desire to be an independent, autonomous agent. He was also tuned into the fact that assisted suicide was illegal in New York which led to his suggestion to seek information from the Hemlock Society. Finally, in his book *Death and Dignity*, he stated that his greatest regret about the care he gave Diane was that she died alone because she did not want to put Quill or her family at legal risk (*ibid.*: 215). I find this to be very telling because it brings to light a relationship sensitivity he had towards her not merely as a physician but also, and more admirably, as a human being. As Aristotle said in *Politics* I 2, we are social animals. Our need for companionship is arguably greatest at times when we are most vulnerable. Quill's wish to be by her side at the time of her death can be construed as an acknowledgement and sensitivity to this important relational aspect of humanity. It also highlights an important reason why assistance in death can be admirable when guided by a caring motive.

BEGINNING OF LIFE

The last issue I would like to explore is one of the more recent to be addressed in the bioethics literature. Resulting from developments in reproductive technology, bioethicists have been discussing the ethical responsibilities of conceiving children with or without the use of such technology. In cases where parents are informed of a significant risk of conceiving a child with a disability and they proceed to do so without reproductive technological assistance, the issue of "wrongful disability" is raised. I would like to examine wrongful disability cases through the lens of the virtue ethics of care and attempt to argue that it handles the issue in a much more coherent and intuitive manner than deontic approaches.

As Allen Buchanan, Dan Brock, Norman Daniels and Daniel Wikler describe it, a wrongful disability case occurs when an infant's harmful genetically transmitted conditions could and should have been prevented but were not. They acknowledge that there are many mitigating factors that could negate the moral label "wrongful", such as the severity of the disability, the options available to the parents to prevent the condition and whether those methods are acceptable to the parents. In the effort to highlight a philosophically problematic aspect of justifying a wrongful disability case, Buchanan and colleagues make use of a hypothetical case, called P1:

A woman is told by her physician that she should not attempt to become pregnant now because she has a condition that is highly likely to result in moderate mental retardation in her child. Her condition is easily and fully treatable by taking a safe medication for one month. If she takes the medication and delays becoming

pregnant for a month, the risk to her child will be eliminated and there is every reason to expect that she will have a normal child. Because the delay would interfere with her vacation travel plans, however, she does not take the medication, gets pregnant now, and gives birth to a child who is moderately retarded.

(Buchanan *et al.* 2000: 244)

Buchanan *et al.* argue (*ibid.*: 245) (and I agree) that common-sense morality will declare that this woman acted immorally and is not morally different from a situation where the condition were discovered during her pregnancy and she did not take the medication or where the condition appeared in her newborn child and she neglected to give him the medicine. But the case P1 poses a substantive problem. Since the alternative would be nonexistence, and a life with a disability is still a worthwhile life, the child might not see the mother's actions as wrongful. If no one is wronged, how can we say that she acted immorally?

Buchanan *et al.* proceed to offer a principle-based solution to this philosophical problem. What they provide is a very precise non-person-affecting principle, arguably an offshoot of the principle of nonmaleficence:

Individuals are morally required not to let any child or other dependent person for whose welfare they are responsible experience serious suffering or limited opportunity or serious loss of happiness or good, if they can act so that, without affecting the number of persons who will exist and without imposing substantial burdens or costs or loss of benefits on themselves or others, no child or other dependent person for whose welfare they are responsible will experience serious suffering or limited opportunity or serious loss of happiness or good. (*Ibid.*: 249)

Whether or not Buchanan *et al.* are successful in working their way through the philosophical problem arising from wrongful disability cases such as P1, I would argue that they do so in a way that seems to be completely disconnected from common-sense morality. Our common-sense aversion to the mother's action does not come from her causing the disability, but rather is focused on her motives. We are appalled because her action reflects an intention to conceive a child based on a superficial kind of selfishness along with a chilling disregard of the real risks in doing so. It is exactly this kind of motive that the virtue ethics of care would find to be utterly deplorable. The role one takes on when becoming a parent and the nature of the parent-child relationship carry with them a number of expectations and commitments a moral agent must be deeply concerned about. An obvious expectation is creating the safest and healthiest environment possible and bringing the healthiest child possible into that environment. The mother in P1 displays no concern for this expectation at all. Instead, her action reflects a deplorable thoughtlessness towards parental responsibility.

Richard Hull, in an essay criticizing Buchanan *et al.*'s treatment of wrongful disability, agrees that it is off the mark to call the mother's actions wrongful through the violation of a non-person-affecting principle. Instead, he focuses on her being irresponsible, "given the ease with which she can bring about a state of affairs that entails less suffering" (2006: 62). Hull also makes an observation similar to mine about how we understand the role of parenthood which plays into the judgement about the mother's motive.

As prospective parents, for example, we tend to take a top down rather than bottom up approach. We think of providing the best possible conditions (social, economic, medical and emotional) in which to raise a child rather than being satisfied to ensure that such conditions are just somewhat above an acceptable minimum.

(*Ibid.*: 60)

While Hull is not explicit about it, I would say that this kind of attitude is what someone who is motivated by ethical concerns for a would-be child would take very seriously.

Specific contextual details will factor considerably into the assessment of parents' motives in cases like this. In-vitro diagnosis of illnesses and health risks is a relatively new phenomenon, and may not be easily accessible or affordable by many individuals who wish to have children. For example; women in the 1920s who smoked cigarettes and drank alcohol while pregnant (let us assume moderately) can not be said to have acted thoughtlessly. Today, with our greater and widely spread understanding of the hazards of even moderate use of these substances on neonatal development, a woman who drinks and smokes while pregnant would act with an insensitive motive.

CONCLUDING REMARKS

I hope that by exploring a number of different issues in medical practice I have given a helpful picture of what "virtue in the clinic" would be like from the virtue ethics of care perspective. The picture is far from complete. As I said at the beginning, the ethics of care in medical practice remains a largely unexplored frontier (although it is explored very thoroughly in van Hooft 2004 and 2006a). One area that looms large on the horizon is the issue of social justice in health care. I intentionally avoided this issue and focused instead on the moral issues surrounding the physician–patient relationship. Still, the morality of patient care, end-of-life decisions and beginning-of-life decisions all raise important questions about social justice, just social institutions and just public policies. Any formulation of virtue ethics will need to take on the challenge of offering a treatment of social justice in health care in purely aretaic terms. Some work has begun on this front with respect to general ethics of care-based theories of social justice and more will undoubtedly be forthcoming.⁷

ACKNOWLEDGEMENTS

I would like to thank Stan van Hooft for providing me the opportunity to contribute this chapter, the anonymous referee for helpful comments and insights on the initial submission, and Alec Julien and J. M. Thomas for comments on earlier drafts.

NOTES

1. In an essay titled "The Virtuous Patient", Karen Lebacqz (1985) discussed this issue from an Aristotelian perspective. Special thanks to the anonymous reviewer who brought this essay to my attention.
2. Michael Slote has offered a thorough empathy-based treatment of respect for autonomy in general (2007: ch. 4; 2010a: ch. 8) and Jodi Halpern (2001: ch. 5) and I (2008) have independently offered our own care-based interpretations of respect for autonomy in medical practice.

3. I am assuming that the patient is fully competent to make such decisions. Cases of questionable or deteriorating patient competence are quite different contexts which I will not go into here.
4. The case was adapted from Gillett (1987).
5. This point is also part of Beauchamp and Childress's conditions for breaching patient confidentiality (2009: 308). However, they will justify such actions in terms of duties to the principles of beneficence or nonmaleficence.
6. I make a similar argument with regard to physician dishonesty in a forthcoming essay, "Admirable Dishonesty in Medical Practice".
7. Examples include Clement (1996), Noddings (2002, 2010), Held (2006), Slote (2007: ch. 6, 2010a: ch. 9).