that the prohibited actions are immoral and so ought not to be performed.

To a considerable extent, laws express the values of a society and the society's judgments about what is morally right. In our society, homicide and theft are recognized as crimes, and those who commit them are guilty of legal, as well as moral, wrongdoing. Society attempts to prevent such crimes and to punish offenders.

The degree to which the law should embody moral judgments is hard to determine. It is particularly difficult to answer in a pluralistic society like ours, in which there may be sharp differences of opinion about the moral legitimacy of some actions. As recently as the mid-twentieth century, for example, materials considered obscene could not be freely purchased, information on contraceptives could not be freely distributed, birth control could not be legally prescribed in many states, and the conditions of divorce were generally stringent and punitive. Even now, all fifty states prohibit polygamous marriages and prostitution is illegal in all states except parts of Nevada. One foundation for such laws is the belief that the practices proscribed are morally wrong.

The ongoing debate over abortion reflects, in some of its aspects, a conflict between those who favor strong legal moralism and those who oppose it. Many who consider abortion morally wrong would also like to see it made illegal once more. Others, even though they may disapprove of abortion, believe that it is a private moral matter and that attempts to regulate it by law are unwarranted intrusions of state power.

The Welfare Principle. The welfare principle holds that it is justifiable to restrict individual autonomy if doing so will provide benefits to others. Those who endorse this principle do not generally present it as requiring major sacrifices of our autonomy or welfare in order to benefit others. Rather an ideal application of the principle would be the case in which we give up only a little autonomy to bring about a great deal of benefit to others.

For example, transplant organs are in short supply because their availability depends mostly on their being freely donated. The situation could be dramatically changed by a law requiring that organs from the recently deceased be harvested and made available for transplant. Such a law would end the present system of voluntary donation, and in doing so it would restrict our freedom to decide what is to be done with our bodies after death. However, it could be argued that the benefit others might gain from such a law easily outweighs the comparatively modest restriction of autonomy that it would involve.

The four principles we have just discussed are not the only ones that offer grounds for abridging the autonomy of individuals, but they are the most relevant to medical policy and decision-making. It is important to keep in mind that merely appealing to a principle is not enough to warrant restrictions of autonomy. A principle points in the direction of an argument, but it is no substitute for one. The high value we place on autonomy gives its preservation a high priority, and compelling considerations are required to justify compromising it. In the view of some philosophers who endorse the position taken by Mill, only the harm principle can serve as grounds for legitimately restricting autonomy. Other theorists find persuasive reasons to do so based on other principles.

BEYOND PRINCIPLISM

Most of traditional Western ethics is based on the assumption that ethical beliefs are best represented by a set of rules or abstract principles. Kant's categorical imperative, Mill's principle of utility, and Ross's list of prima facie duties attempt to supply guides

for moral action and decision-making that apply in all circumstances.

Moral decisions thus typically involve bringing a case under a rule, similar to the way that courts apply statutory laws to cases brought before them. Much ethical debate, like much legal debate, concerns whether an abstract rule does or does not apply in a concrete case.

In recent decades, however, some ethical theorists have turned away from the principle-governed, legalistic approach to ethics in favor of various alternative approaches. Some of these theorists have emphasized the importance of character as the source of moral action, whereas others have stressed the central role of shared concerns and the crucial importance of social practices and institutions in shaping our moral lives.

We will present here some brief sketches of ethical approaches that (according to their proponents) cannot be reduced to sets of abstract principles. Although moral theorists debate such questions as whether the virtue of being a truthful person (a character trait) isn't ultimately derived from the duty to tell the truth (a principle), we will steer clear of these issues. Rather, as with theories based on principles, we will restrict ourselves to a general statement of each alternative approach, indicate how it might be applied in a medical context, and then discuss some of the difficulties it faces as a moral theory.

The four theories discussed here have been presented by their proponents in a variety of versions, some of them quite elaborate and philosophically sophisticated. Here, however, we will be presenting only sketches.

The Capabilities Approach

One recurrent criticism of principle-based ethical theories is that they fail to adequately address human diversity and the profound impact that personal and social differences may have on individual lives. For example, we have seen how the principle of utility appears to tolerate exploitation or even slavery, provided that the unhappiness of a subordinate minority is outweighed by the happiness of the dominant group. Even the more nuanced versions of the utilitarianism, such as those based on individuals' expressed desires, face the problem of *adaptive preferences*. As demonstrated by economists such as Amartya Sen, people in subordinate roles typically learn to stop wanting social goods that have been put out of their reach. Thus, for a variety of reasons, principles that reduce questions of morality and justice to a single subjective standard (e.g., satisfactions or preferences) may end up reinforcing an unjust status quo.

At the same time, principles that evaluate morality and justice using a uniform objective standard (such as a fair share of material resources) have their own difficulties handling interpersonal differences. As Sen famously observed in his critique of John Rawls's account of *primary goods* (which uses wealth and income for interpersonal rankings), a poor person with a serious disability will need a considerably larger share of resources to achieve the same level of well-being as an equally poor person who has no significant impairments. To take another example, pregnant women and children require considerably more protein to achieve the same level of health and well-being as other members of society.

It should be noted that many of these differences are not just individual, but *social*, and may thus require structural change and not just material compensation. A society whose culture devalues female offspring may not only have to spend disproportionately more on girls' health and education, but also may also need to actively promote cultural change, if it is to grant women full citizenship. Similarly, a society with a built environment exclusively designed for "normal" adult

citizens who can (at least temporarily) climb stairs and stand upright may need to provide such accommodations as ramps, lifts, and accessible bathrooms if it seeks to promote the genuine well-being of citizens who use wheelchairs. By pursuing a homogenous, abstract standard of social good, critics charge, traditional theories often fail to account for the substantively different opportunities that people have (or don't have) in their lives.

As a corrective to such theories, economists such as Sen and philosophers such as Martha Nussbaum have developed the *capabilities approach* to social justice and interpersonal comparisons of well-being. When evaluating social policies and practices, this approach recommends that we ask, *What is each person actually able to do and to be?* In other words, just societies and individuals should focus on the set of substantial freedoms or opportunities that each person, viewed as an end in herself, can actually choose to exercise. Rather than reducing these substantial freedoms or *capabilities* to an abstract scale of value (such as utility, wealth, or per-capita gross national product), justice entitles individuals to a core set of qualitatively distinct *central capabilities* that are, according to Nussbaum's version of the approach, implicit in our basic understanding of human dignity.

With this emphasis on respect for the freedom and dignity of every individual viewed as an end in himself, the capabilities approach has many affinities with the deontological ethics of Kant, Ross, and Rawls. But Nussbaum and Sen question deontology's tendency to rely on "automatic" decision procedures—based, for example, on the categorical imperative or the original position—to determine the right action, policy, or principles. Instead, like consequentialists, they argue that policies and practices should be evaluated in the light of their *outcomes*: whether they actually help people achieve the minimum threshold of capabilities that they have good reason to value.

The capabilities approach also rejects the assumption, present in both Kant's and Rawls's account of social cooperation, that it must be pursued by and for the *mutual advantage* of free and equal parties with a high level of rational autonomy. Nussbaum notes that such views not only exclude cognitively impaired people from the entitlements of justice and personhood, but also fails to reflect the large portion of most "normal" people's lifespans that is spent in states of dependency, vulnerability, and asymmetrical relationships. These states constitute an important part of our human dignity and rationality, not something to be contrasted with it—a point that will also be emphasized by proponents of care ethics (see below). The result is a broader conception of human agency, rooted in "active striving," and an account of social cooperation that incorporates benevolent and altruistic motives, not just the pursuit of mutual advantage.

Central Capabilities

If the capabilities approach relies neither on mechanical decision procedures nor on applying abstract principles to cases, then how is it to guide moral decision-making and just policy-making? Nussbaum proposes that the justice of societies and policies be evaluated on the basis of ten central capabilities. Beneath a specified minimal threshold of each of these central capabilities, she argues, individuals are unable to lead lives worthy of their human dignity and cannot achieve genuine human functioning:

1) *Life.* Being able to live a normal human lifespan; 2) *Bodily health.* Being able to achieve good health, most fundamentally on the basis of adequate nutrition and shelter; 3) *Bodily integrity.* Being able to move safely in one's environment, free from violence or sexual assault, and exercising reasonable control over one's reproductive and sexual life; 4) Being able to use one's *senses, imagination, thought, and reason*, especially as facilitated by literacy,

numeracy, and freedom of expression and worship; 5) *Emotions.* Being able to form the range of attachments and relationships crucial for human development; 6) *Practical reason.* Being able to plan and pursue a life in accordance with one's own conception of the good; 7) *Affiliation.* Being able to engage in social interactions consistent with both self-respect and solidarity, enjoying freedom of assembly and freedom from systematic discrimination; 8) *Other species.* Being able to live as part of the natural world of plants and animals; 9) Being able to enjoy *leisure time and play*; 10) Being able to exercise reasonable *control over one's material and political environment*, through equal basic political rights, property rights, employment opportunities, and freedom from unwarranted search and seizure.

We do not have space to summarize Nussbaum's arguments for each of these central capabilities, but a few points are needed to complete our sketch. First, these capabilities are plural and *incommensurable* sources of value—a just society cannot compensate a lack of basic voting rights with better health care. Second, the capabilities are presented as freestanding political goals that could form the basis of an overlapping consensus in a pluralistic society. In keeping with Rawls's idea of *political liberalism* (see above), Nussbaum does not argue for the capabilities on the basis of any particular comprehensive view of religion, philosophy, or human psychology. To explain why leisure and play should receive special protection in a just society, for example, she seeks to demonstrate, on an empirical and intuitive basis, how those deprived of leisure (e.g., who must work multiple jobs or who have a "double day" of both formal employment and unpaid caregiving) are ultimately unable to access the set of capabilities that constitute a full and dignified human life.

Finally, it is important to distinguish capabilities (what agents can be and do) from realized *functionings* (their actual beings and doings). Sen and Nussbaum argue that just policies should generally promote only the former and not the latter, in keeping with their emphasis on human agency and reasonable pluralism.

The Capabilities Approach in the Medical Context

From its origins in the work of Amartya Sen and the United Nation's *Human Development Index*, the capabilities approach has taken health and healthcare as a primary focus. This is partly because health can be a profoundly "fertile" capability (facilitating many other substantive freedoms) or a profoundly "corrosive" one (eliminating other capabilities). Drawing heavily on Rawls's theory of justice, the approach is also especially concerned with the long-term health effects of poverty, particularly on an international scale. Minimally decent societies and policies should try to prevent "morally arbitrary" factors, such as being born to a mother with no health insurance and poor prenatal nutrition, from condemning individuals to a life that falls below basic capability levels.

But health policies must also look beyond mere *means*, such as distribution of resources, to examine how individual and social differences limit what people can actually do and be. A person afflicted by intestinal parasites has limited capability to convert a fair share of food into healthy human functioning. Similarly, achieving a just social minimum in a culture that tolerates widespread economic discrimination or sexual violence against girls and women may require special efforts to help them reach a basic level of health and related capabilities. Pursuing the central capability thresholds may require similar efforts by physicians and policy-makers to support the health of groups that are despised or marginalized on the basis of religion, ethnicity, caste, sexuality, or other factors.

Such obligations are particularly demanding when it comes to people with serious

physical and mental impairments. Rather than treating the disabled as if they belonged to a different species, we are to promote all ten central capabilities implied by their worth and dignity as members of the human species. This moral claim applies to all degrees of physical and mental disability, with the exception of those in anencephalic and permanent vegetative states (who are judged incapable of the "active striving" necessary for genuine human functioning). Thus, a just society will likely direct resources not just to accessible public accommodations, but also to new avenues of social and political participation for the disabled. This requirement derives, in part, from the recognition that all members of society experience extended states of impairment and dependency that should not, insofar as possible, prevent them from achieving central human capabilities.

Of course, the approach would not force the disabled (or anyone else) to achieve actual *functionings* such as voting or literacy or cultural expression, but only work to provide them with substantive freedom to pursue these varied dimensions of human life. On similar grounds, the capabilities approach would also reject mandatory lifesaving interventions (such as blood transfusions) for those who refuse them (such as Jehovah's Witnesses). In Sen and Nussbaum's view, there is a significant moral difference between policies that promote health and those that promote *health capabilities*—only the latter is an appropriate goal for a just and pluralistic society.

Difficulties with the Capabilities Approach

Like some other pluralistic approaches to value (such as that of W. D. Ross, discussed above), the capabilities approach has been criticized for relying on "intuitionistic balancing" when it comes to competing ends. Without a uniform standard to evaluate the right or the good, how are we to choose among competing capabilities, or, for that matter, competing claims to the human dignity that those capabilities are said to embody? (The conflicts of moral standing frequently invoked in the abortion debate would seem to exemplify these competing claims.) Thus, critics charge, capabilities provide insufficient guidance for biomedical and other moral decisions.

Defenders of the approach point out that traditional ethical theories also tend to rely on intuition when it comes to first principles (such as utility or autonomy) and the design of decision procedures (such as Rawls's original position). They argue that the capabilities approach involves no "balancing," since justice requires that a minimal threshold of all ten central capabilities be met. Proponents such as Nussbaum have also provided an account of abortion that, while granting a fetus's possession of human dignity, argues that its capabilities are primarily potential and dependent. Thus, its claim to moral standing must, for a large set of cases, be trumped by protection of the pregnant woman's central capabilities. (Its claims may, however, allow for restrictions on abortions for some dubious reasons, such as sex-selection, and limits on how late in pregnancy abortions may be performed, with exceptions for women's life and health.)

Despite such applications, neither Sen nor Nussbaum claim that their account of capability is a full-fledged ethical theory but rather a framework for comparative quality-of-life assessment and a "partial" account of social justice. Although influential in development economics and in some constitutional law debates, the capabilities approach is just a few decades old. It remains to be seen if it will retain its appeal as it is applied to an increasing number of problems in bioethics, public policy, and beyond.

Virtue Ethics

Every culture is populated by real and fictional figures who represent the sort of

people we may seek to become. Some figures are seen as perfect, while others are people who, despite their flaws, demonstrate *character* in confronting life's problems and struggles. To name only a few historically important figures, consider Moses, Gautama Buddha, Socrates, Confucius, Jesus, Marcus Aurelius, Augustine, Voltaire, Harriet Tubman, Abraham Lincoln, Karl Marx, Susan B. Anthony, Florence Nightingale, Anne Frank, Mohandas Gandhi, Martin Luther King, Jr., Mother Teresa, and Nelson Mandela. It would be easy to make an even longer list of fictional characters who evoke our admiration and make us feel that we would be better people if we could be more like them.

Virtue ethics is ethics based on character. Its fundamental idea is that a person who has acquired the proper set of dispositions will do what is right when faced with a situation involving a moral choice. The virtuous person is both the basic concept and the goal of virtue ethics. The virtuous person is one who does right, because she is just that sort of person. Right actions flow out of character, and the virtuous person has a disposition to do the right thing. Rules need not be consulted, calculations need not be performed, abstract duties need not be considered.

On this view, people become virtuous in the same way they become good swimmers. Practice, personal effort, and reflection, as well as upbringing and education, all play a role. As with swimming, some people may be more naturally inclined to become virtuous than others. Those who are naturally patient, reflective, and slow to anger may find it easier than those who are impatient, impulsive, and short-tempered.

Families and social institutions—such as schools, clubs, and athletic teams, as well as religious institutions—play a role in shaping our moral character. They tell us how we should behave when we lose a school election or win a soccer game. They teach us what we should do when we have a chance to take money without anyone's finding out, when we witness a case of discrimination or harassment, or when we ourselves are treated unfairly.

Quite apart from explicit teachings or doctrines, the lives of historical figures such as Jesus, Mohammed, and Buddha have served as examples of what it is possible for a person to become. Perhaps no one can achieve the level of moral perfection such people represent, but they offer us models for fashioning ourselves and handling everyday moral questions.

When a Christian asks, "What would Jesus do?" it is not typically a call for divine intervention. Rather, it is an occasion for reflection, for trying to imagine what someone living a life like Jesus's would do. We try to improve our character by becoming more like those who are admirable. Hence, in addition to education and social influences, we must engage in self-criticism and make deliberate efforts to improve.

The Virtues

Like the capabilities approach, virtue ethics provides a plural account of values, and both have roots in the Greek philosopher Aristotle's account of the varied dimensions of human flourishing. *Virtue* is a translation of the ancient Greek word *arete*, which can be loosely translated as "excellence." (Virtue ethics is also called *aretaic ethics*.) The excellent tennis player demonstrates in playing tennis that she possesses characteristics needed to play the game well. Similarly, the virtuous person demonstrates through living that she possesses the appropriate range of excellences.

Virtues have traditionally been categorized as either moral or nonmoral:

> Moral virtues: *benevolence, compassion, honesty, charity, sincerity, sympathy, respect, consideration, kindness, thoughtfulness, loyalty, fairness, and so on.*

Nonmoral virtues: *rationality (or intelligence), tenacity, capability, patience, prudence, skillfulness, staunchness, shrewdness, proficiency, and so on.*

The distinction between moral and nonmoral virtues is far from clear, but the rough idea is that those in one set are associated with living a good (moral) life, whereas those in the other are associated with practical aspects of living. A thief can be patient (a nonmoral virtue), but not fully honest (a moral one). By contrast, an honest person may lack patience. How to classify *courage* presents a problem. A courageous thief may be more successful than a cowardly one, but a benevolent person lacking the courage to put his views into practice will be ineffective.

Virtue Ethics in the Medical Context

Consider the hypothetical example of Dr. Charles Holmes, an orthopedic surgeon who has chosen his specialty because the money is good and the hours reasonable. He treats the patients and then he goes home. Holmes has technical expertise, but he lacks compassion for his patients and is not interested in their values or hopes for their lives. He shows no tact in dealing with patients' fears and questions, and barely acknowledges that they are people.

Dr. Holmes is far removed from our notion of what a physician as a compassionate healer should be. In treating his patients as broken machines, he may help them in important ways, but his skills as a physician are deficient. Holmes, we might say, lacks the disposition necessary to be an excellent or even a good physician.

From at least the time of the ancient Greeks, the Western tradition in medicine has expected physicians to be virtuous, and more recently that expectation has expanded to include nurses, medical technicians, and all who care for patients. Medical history includes many accounts of caregivers whose actions make them moral examples. During the Black Death (bubonic plague) pandemic in fourteenth-century Europe, scores of physicians tended to their patients, even though they risked infection themselves. The British nurse Florence Nightingale, braving harsh conditions and the threat of death, helped care for troops during the Crimean War and helped establish nursing as a profession. In recent years, African and Western medical professionals have taken considerable risks to combat the Ebola epidemic in West Africa, and dozens have been infected with the deadly virus while caring for patients.

Virtue ethics calls attention to medicine at its moral (and practical) best. Courage, loyalty, integrity, compassion, and benevolence, along with determination and intelligence, are virtues associated with physicians and others who provide what we consider the right sort of care for their patients. Virtue ethics, with its emphasis on character and behavioral dispositions, comes closer to capturing our notion of the ideal health professional than do rule-based accounts of moral decision-making such as Kant's ethics or utilitarianism.

Difficulties with Virtue Ethics

A fundamental difficulty with virtue ethics is that it provides us with no explicit guidance in deciding how to act in particular circumstances. Suppose someone is terminally ill, in great pain, and asking for assistance in dying. Should we agree to help? We may ask, "What would Jesus do?" and the answer may be "I don't know." Medicine constantly faces the problem of deciding what specific actions ought to be taken, but virtue ethics is about character and dispositions. Even a perfectly benevolent person (one disposed to act benevolently) may not know how to distribute organs that are in short supply. Further, virtue ethics does not supply any clear way to resolve moral conflicts. What if one gynecologist thinks it wrong to

abort a fetus at twenty-three weeks gestation, but another does not? How can they go about resolving their dispute using the concept of virtue? The answer is not clear.

Also, virtues, like duties, can be incompatible when put into action. If I am a transplant coordinator and try to show gratitude to my pastor by allowing her to jump to the top of the waiting list for a liver, this action will conflict with my commitment to fairness. But if virtues are not ranked, how do I decide whether to prioritize gratitude or fairness? Surely we don't think it would be right for me to put my pastor at the head of the list, but on what grounds can virtue ethics say that it would be wrong?

Care Ethics

With their emphasis on abstraction, philosophers sometimes seem to forget that our moral life typically takes place in the context of ongoing relationships of mutual understanding, concern, and obligations to specific individuals. That such relationships involve nuanced moral responsibilities that cannot be captured by abstract principles is a conviction that helps motivate *care ethics* as a theoretical approach to interpersonal morality. Care ethics is not, however, a unified doctrine that can be captured in a set of formal statements. It is perhaps best characterized as a family of beliefs about the way values should be manifested in character, behavior, and social practices. It is unified by a set of shared concerns and commitments, as well as by its critique of traditional Anglo-American approaches to philosophical ethics.

Much of the early philosophical work in care ethics grew out of the feminist movement and psychologist Carol Gilligan's research on gender differences in moral development. Gilligan's work is, in part, a response to that of her academic mentor, Lawrence Kohlberg, who had concluded that women were "less developed" in their moral reasoning than men, because they appeared less adept at applying universal principles to particular cases. Gilligan rejects Kohlberg's hierarchical account of moral development and instead argues for an alternative, but equally legitimate, *style* of moral reasoning that she finds to be more common in women than men.

Gilligan famously reinterprets a classic case from Kohlberg's research, in which a girl and a boy were asked whether a (fictional) man named Heinz should steal an overpriced drug he cannot afford, in order to save the life of his ailing wife. Gilligan takes the girl's answer—that Heinz should not steal the drug, lest he go to prison and leave his wife in an even worse situation—to exemplify an ethical style focused on the specific interests of multiple people in communicative relationships over time. She takes the boy's conclusion—that Heinz *should* steal the drug because the right to life takes priority over property rights—to represent the individualistic and mechanical application of principles more characteristic of men and male-dominated academic philosophy.

Based on Kohlberg's and her own subsequent studies, Gilligan argues that women are more likely to view ethical dilemmas in terms of a network of ongoing relationships, in which compromise, creativity, and communication are necessary to resolve conflicts in a way that minimizes harm and respects everyone's interests. By contrast, Gilligan argues that men are more likely to try to resolve moral conflicts by applying abstract rules, even if that means ignoring the specific characteristics and needs of some of the people involved in the situation.

Gilligan characterizes the more typically female response to situations of moral conflict as expressing an *ethic of care* and the more typically male response as expressing an *ethic of justice*. She emphasizes, however, that there isn't a consistent correlation between these types of response and gender. According to Gilligan, ideal moral agents

should employ both approaches to ethical decision-making, even if there is currently a gender-based asymmetry in their use. The question of whether care ethics is a specifically *feminine* mode of reasoning, however, has been a source of ongoing debate as care ethics has evolved. So has the question of whether it constitutes an outgrowth or a particular strand of *feminist ethics* (which will be discussed in the next section).

Some philosophers have reserved the term *feminist* for approaches that also examine care and caregiving in the context of gender-based power imbalances and divisions of labor between men and women. *Feminist ethics*, on this view, is primarily concerned with the symbolic and empirical structures of gender and how such structures might be changed to achieve full social and political equality for women and men. *Care ethics* need not have such explicit feminist concerns, although it may share the same general aims and point of view.

Even so, many feminists see this terminological distinction as less important than the need to make sure that women's perspectives and concerns are represented within ethics. According to them, the ethical tradition has concentrated on the development of sweeping abstract theories that fail to acknowledge the importance of values more typically prized by women; as a result, philosophers have traditionally assigned those values little or no role in moral decision-making or the moral life. Care ethics is seen as a means of enriching philosophical ethics with moral insights derived from interdependent caregiving relationships, nuanced communication skills, and reasoning from particular cases.

Values, Not Principles

Ethical theories as diverse as utilitarianism and Kantian ethics have in common a reliance upon abstract principles, both as an expression of the theory and as a means of resolving moral conflicts. Thus, to decide whether an action is morally legitimate, we can appeal, for example, to the principle of utility or to the categorical imperative. Moral theories can be viewed as providing a decision procedure for arriving at morally justified conclusions in particular cases: to justify an action, bring it under a rule.

Care ethics questions whether it is appropriate to rely on abstract rules or principles where certain kinds of relationships are concerned. Should we perform a utilitarian calculation before giving a friend a ride to the hospital? Should parents consult the categorical imperative before deciding whether to immunize their children against polio? Of course not. Relationships such as friendship and parenthood require that we give of ourselves and provide appropriate assistance and care. These demands are bound up with the trust, vulnerability, and commitment that characterizes ongoing relationships. Other interpersonal roles—being a spouse, aunt, uncle, grandparent, pastor, nurse, physician, teacher, or therapist—involve other complex relational requirements. To treat people in such relationships as if they were simply unconnected autonomous agents, bound only by abstract moral rules, seems both inappropriate and bizarre.

Care ethics rejects outright the idea that abstract principles can capture everything relevant to making moral decisions. It reflects a deep skepticism that our moral lives with others can be subsumed "under a rule" or shown to be an "instance" of a general principle. This does not mean, however, that care ethics views our relational duties as merely intuitive, subjective, or a natural outgrowth of love. Indeed, care ethics, like feminist ethics more generally, is highly critical of the notion that caregiving duties (i.e., those of mothers) are natural, blindly emotional, or beyond rational scrutiny. Instead, care ethics insists that we derive our moral duties from a sophisticated understanding of the specific relational context in which a moral problem

has arisen. This requires a deep and detailed understanding of the people involved and their interests and feelings. Only then is it possible to resolve the problem in a way that is sensitive to everyone's needs.

In evaluating such situations, we must use critical intelligence to grasp relationships and details about the people, the circumstances, and the moral problem. But equally important, we must use *empathy* to understand the concerns and feelings of the people involved. We must identify with those in need or conflict, see what is at stake from their point of view, and ascertain their worries and concerns. We must also bring to the situation of moral conflict or doubt such traditional "women's values" as caring, consideration, compassion, understanding, generosity, humility, and a willingness to assume responsibility.

These are the very values we must rely on to resolve moral conflicts and address the needs of the people involved. Such a process must go beyond determining who is in the wrong or being treated unfairly. Rather, the point is to find a way out of the conflict that takes into account the concerns and feelings of those involved.

According to care ethics, the traditional ethical model of a disinterested, detached, and dispassionate judge reviewing the objective facts in a case and then issuing an impartial decision about the moral acceptability of an action is both inappropriate and inadequate. It excludes the very values that are most relevant to moral situations and most important to the people who are involved. Moral decisions should not be impartial, in an abstract and bloodless way; rather, they should show partiality to *everyone* involved.

Like virtue ethics, care ethics emphasizes the development of an appropriate character. As a society, we should make an effort, by teaching and example, to develop individuals, both male and female, who respond appropriately to moral situations. They should be people who recognize the importance of personal relationships, respect individuals, and accept responsibility. If they have acquired the proper character and interpersonal skills, they will bring to bear the values (described above) that we associate with caring for and about people.

Care Ethics in the Medical Context

Suppose the parents of a severely impaired newborn boy are told by the child's physicians that his treatment ought to be discontinued and he should be given only "comfort care" and allowed to die. The parents' initial response is to reject the recommendation and insist that everything possible be done to preserve the life of their child. How might such a conflict be resolved by the approach advocated by care ethics?

The parties to the conflict must discuss their positions freely and openly. (We need not assume that only two positions are involved.) The physicians must explain in detail the baby's medical condition, discuss the therapy they may be able to offer, and be forthcoming about its limitations. If they believe the child will die in a few hours or days, no matter what they do, they must be both candid and sensitive about this expectation. They might gently point out that the only possible intervention involves extensive and painful surgery, that it is almost certain to be unsuccessful, and that it will make demands on the resources of the hospital, the society, and the parents themselves.

For their part, the parents might talk about their hopes for their son and their willingness to love and nurture a child with severe physical and mental impairments. They might discuss the guilt they would feel about giving up the struggle and allowing the child to die. They might discuss their experiences with other children or talk about the difficulties they had conceiving the baby who is now not expected to live.

No particular outcome can be predicted from such a discussion. We might imagine education taking place and compromises developing. We might imagine the physicians coming to a greater appreciation of what the child means to the parents and why they are so reluctant to allow him to die. The parents, for their part, might come to understand that the physicians are concerned for their family and are also frustrated and saddened by their inability to help the child get better. Such an exchange might involve adjustments on the part of all participants. The parents might come to realize that their child is almost certain to die no matter what is done. The physicians might realize that they can make the death easier for the parents to bear by allowing them to hold the child and spend time with him.

Other moral conflicts or questions might be approached in a similar fashion. How should family members and physicians handle a terminally ill patient's request for assistance in dying? How should health providers approach the second-trimester abortion request of a pregnant woman with bipolar disorder who lives below the poverty line? Care ethics insists that we not abstract from the details of these cases and retreat to universal principles. Instead, the complexities of the people and relationships involved are essential moral data. This is particularly true, care ethicists suggest, when the relationships involved are *embodied* and *dependent*, involving intimate caregiving duties, familial bonds, and, in pregnancy, shared bodily space and merged human existence.

Medicine, nursing, and related disciplines have traditionally been associated with the values of caring. We have expected practitioners to manifest, in their character and conduct, such qualities as concern, compassion, sympathy, kindness, and a willingness to take responsibility and to help patients in their charge. In this respect, care ethics is asking us to recognize a traditional approach to biomedical practice. However, care ethics also reassures us that this approach is legitimate, even though no abstract principles are involved. Further, it demonstrates how we may rely on those same values and dispositions when we are faced with moral conflicts in medicine.

Difficulties with Care Ethics

A frequent criticism of care ethics is that Gilligan's empirical claims about the different moral reasoning styles of women and men are not confirmed by more recent data. Without taking a stand on this question, we can observe that these empirical claims are not crucial to care ethics. It is enough for the theorist to demonstrate the importance of the values that belong to the ethic of care—by demonstrating their pivotal role in the moral life of individuals and society, and how they can be employed as guides to resolve cases of moral doubt and conflict.

Other critics have argued that although care ethics usefully claims moral values and practices often ignored or unappreciated in traditional ethics, it does not constitute a separate, full-fledged theory, such as utilitarianism or Ross's intuitionism. Some have suggested, for example, that the principle of beneficence ("Act so as to promote the good of others") can be construed as implying a duty to care. Some care ethicists have endorsed the use of such a principle, while others have insisted that the care ethic remains distinct from the traditional enterprise of philosophical ethics.

A more important criticism may be that, like virtue ethics, which also typically rejects principles as necessary to moral reasoning, care ethics provides us with no clear procedure for resolving moral conflicts. We may approach such conflicts with all the values implicit in a care ethic and still not know how to make a decision. When a number of people are in need of the same kidney for

transplant, how should we decide who gets the organ? Should we, in the manner suggested by care ethics, have a discussion with them all, listen to their needs and concerns, and then make a decision? It seems unlikely that such a group could reach a consensus, particularly in the short time allowed under such circumstances. If we make a choice among these individuals' conflicting needs and values, some will claim that they have been treated unfairly, no matter how nuanced our understanding of their specific circumstances. Such cases suggest that an abstract principle of justice may, at least in some situations, yield more satisfactory results than the values of care ethics.

These objections might be answered satisfactorily by care ethicists. Even so, they are prima facie shortcomings that require serious responses.

Feminist Ethics and Critical Theories of Identity

Over the past half century, a variety of theories have been developed to explore the ethical implications of political and social categories such as gender, race, sexuality, and disability. Academic disciplines such as critical race theory, queer theory, and disability studies have focused not just on personal identity, but also on how it is shaped and positioned in social and political life. This approach was largely pioneered by work in feminist ethics, which will be our primary focus here—in part because feminist thought has had the most sustained influence on contemporary academic philosophy.

From the perspective of feminism and other identity-based theories, the "principlism" of traditional Anglo-American ethics is compromised by the facts of the social world. The unequal distribution of political and social power and the inequalities attached to the accidents of birth, race, gender, and sexual identity mean that even such basic principles as autonomy may be restricted or distorted in their application. Indeed, as we have seen in our earlier discussion of the capabilities approach, universal principles and uniform metrics of well-being can sometimes mask profound disparities among different groups and individuals.

For example, when the burdens of child-rearing (not to mention gestation) fall exclusively or disproportionately on women, a principle of reproductive autonomy will mean something very different for women than it does for men. Similarly, universal principles of bodily integrity, consent, and freedom of association may provide few protections for women or LGBT individuals if society tolerates widespread patterns of sexual violence and harassment against them. Classical liberal principles of civil rights and economic freedom may elude people of color if they become subtly but indelibly associated with criminality or deviance in the eyes of police officers and loan officers.

The ideal of an autonomous ethical subject, applying universal principles and operating outside of social power relations, is, according to most of these theories, little more than a self-serving fiction. It is only plausible, they argue, if one enjoys the social privileges that come with such attributes as financial security, whiteness, masculinity, heterosexuality, or the absence of disability. Genuine social equality is necessary for the exercise of autonomy, and such equality does not exist under present social conditions. People constrained by discrimination, dependence on others, or disproportionate caregiving responsibilities are not equal to those who are free of such burdens, and thus lack their autonomy. Evidence of such disparities may be dramatic and concrete—exemplified by the number of women in the U.S. Congress, the percentage of women who have experienced

sexual assault, or the percentage of African American men who will be incarcerated during their lifetimes. It may also be subtle—exemplified by the ways in which what is socially acceptable or healthy comes to be associated with European culture or heterosexuality. Both types of evidence are marshaled by critical theories of identity to argue for an alternative approach to ethical deliberation.

Identity-focused theorists insist that ethics should first address unjust social arrangements, practices, and institutions, rather than debate abstract principles. As this approach first developed in feminist ethics, it has often been concerned with uncovering and eliminating the sources of inequality. Feminist theorists have critiqued institutions and social practices that undermine women's agency in the workplace, the family, and in sexual and reproductive relationships. As Susan Sherwin puts the point, feminist ethics cannot be satisfied just by calculating increases in happiness and invoking moral principles. Rather, it must also ask *whose* happiness is increased and how the principles affect different individuals in social and cultural hierarchies. In the final analysis, she writes, "Positive moral value attaches to actions or principles that help relieve oppression, and negative value attaches to those that fail to reduce oppression or actually help to strengthen it."

In practice, ethical theories of identity have often focused on the way cultural *structures*, such as those that sustain gender or race or heterosexuality, come to reinforce hierarchies of power and privilege, and may distort the perceptions of people in both dominant and subordinate groups. Critical race theory, for example, examines how the "color-blind" assumptions of social policies and academic theories often mask pervasive patterns of institutional racism and white privilege. At the same time, queer theory has analyzed how the enforcement of "compulsory" heterosexuality grants extensive privileges to straight, gender-conforming couples while stigmatizing others as deviant or unnatural. Drawing on (European) continental philosophy, these ethical approaches are often conceived as *critical* or *deconstructive*, which often means that they focus on the morally arbitrary, self-contradictory, or internally incoherent aspects of such concepts as "whiteness," "disability," "deviance," or "femininity."

Not surprisingly, this critical strategy sometimes comes into conflict with earlier approaches to interpersonal morality, such as care ethics. Some feminist scholars, for example, find Gilligan's version of care ethics too reliant on "essentialist" or stereotypical notions of women as emotion-driven, self-effacing, or focused on parochial domestic concerns. They argue that this ignores the unequal division of caregiving labor and other power imbalances that have limited women's participation in public life. At worst, they claim care ethics risks valorizing oppressive social structures, such as those that have historically confined women to the lower "helping" ranks of medicine and education, and burdened them with a "double day" of formal employment and domestic caregiving. Caring has a legitimate place in feminist ethics, they argue, but it must be seen as a disposition desirable for all people across divisions of gender, class, race, sexuality, and disability.

Critical Theories of Identity in a Medical Context

Since identity-based theories of ethics encompass a wide range of political movements and intellectual commitments, it would be difficult to provide a unified account of their approaches to medical research and practice. Nevertheless, we can at least describe some of the recurrent themes and strategies of their work in biomedical ethics and highlight a few representative issues.

First, in keeping with the critical and deconstructive approach described above, identity-based approaches often scrutinize biomedical concepts, ranging from controversial diagnoses such as "premenstrual dysphoric disorder" and "gender dysphoria" to more general notions like health, disability, and race. They are particularly concerned with the ways in which such concepts have positioned the members of subordinate groups as aberrant, diseased, or deficient in relation to an arbitrary model of the healthy human body (often explicitly defined as male, white, non-disabled, etc.). The Briefing Session in Chapter 10 considers a number of these concepts and their relationship to social and political power structures.

Second, identity-based theories have advanced a range of arguments on specific biomedical policy issues such as race-based medicine, cochlear implants, assisted reproduction, and abortion. Feminist philosophers, for example, have argued that without reliable access to contraception and abortion, women effectively become "fetal containers," who lack the autonomy that men take for granted in their familial, economic, and sexual lives. At the same time, feminist scholars have explored the overlapping identities and embodied experiences involved in pregnancy, and argued against the adversarial model employed in many discussions of "maternal–fetal conflict."

Third, feminist and other identity-based theories have proposed specific strategies for the evaluation and care of patients. Many of these involve attention to the "intersecting" roles of different social categories and experiences in a patient's life. Consider, for example, a widowed seventy-two-year-old Latina patient with leukemia and difficulty walking who says she may refuse a second course of chemotherapy and sign up for hospice. An identity-based approach to this woman's situation might encourage providers and others involved in her care to consider the following sorts of questions: (1) Does the woman believe she is not entitled to further treatment based on traditional gender norms regarding female self-sacrifice and other-focused caregiving? (2) Have the woman's providers offered her the same aggressive treatment options that they would offer comparable patients of European ancestry? (Some studies suggest that physicians, on average, offer less aggressive interventions to nonwhite patients.) (3) Does the woman lack assistive resources (e.g., a motorized scooter, home health aide, or accessible transportation) that might allow her to maintain social relationships and participate in public life, despite her physical impairments? (4) As a widow, does the woman believe she has no valuable function left in life, beyond heterosexual marriage or maternal caregiving? Does she feel like a burden to her adult children and useless to the broader society?

In sum, providers and others are encouraged to view the woman's decision to discontinue treatment as potentially involving many other factors beyond patient autonomy and informed consent. They are asked to examine how a variety of social and cultural factors might be influencing her decision and making it less than free.

Difficulties with Identity-Based Ethical Theories

The multiplicity of viewpoints and conceptual strategies involved in each of the identity-based theories discussed above has led some critics to charge that none provides the relatively unified set of moral concepts offered by theories such as utilitarianism or Kantian ethics. Some identity-focused ethicists have responded by insisting that moral knowledge is not essentially theoretical and denying that the proper role

of ethics is to provide us with "automatic" decision procedures for action. Rather, ethics is about people, and it has the aim of facilitating their mutual understanding and accommodating the differences among them. Only by engaging in constructive critique and exchange across difference can individuals resolve conflicts and find solutions to their problems.

One difficulty with this view of ethics is that while it has many strengths for analyzing injustice at the level of policy, culture, and social practice, it can seem ill-equipped to confront cases of individual wrongdoing. Suppose someone who is HIV positive claims that he has no responsibility to warn sexual partners of his HIV status or to practice safe sex. "That's their problem and their risk," he says. It is not immediately clear on what grounds an identity-based theory might criticize his position, assuming it is not rooted in prejudice or privilege. It is also not clear how such theories might offer support for the man's position. If we decide that asking for "grounds" is simply the wrong approach, then what is the right approach to resolve the problem of someone's acting in ways that will endanger others needlessly?

A second difficulty of this view of ethics is that it seems to open identity-based approaches to the charge of cultural relativism. If ethics is (in Margaret Urban Walker's phrase) a "socially embodied" practice involving critique and dialogue *within* cultural structures, on what basis can it make moral assessments from *outside* a particular culture? As discussed in Chapter 11, practices such as slavery, child marriage, and genital cutting may be rooted in elaborate, culturally specific justifications. Without recourse to some universal principles, it is not clear how outsiders can support reformers in other cultures against those who wish to perpetuate socially oppressive practices. As with virtue ethics and care ethics, a commitment to doing without principles or rules doesn't seem to offer a way of assessing actions, policies, and practices from the outside.

To be sure, many feminist and other identity-focused theorists acknowledge a role for universal moral concepts, so long as they are not employed to simply ignore or bypass the impact of social power structures. There are, for example, many feminist philosophers whose critiques of misogynistic behavior or patriarchal culture is rooted in a neo-Kantian, contemporary utilitarian, or another "hybrid" approach. Others, such as Martha Nussbaum, offer universal concepts (e.g., the central capabilities discussed above), which are designed to advance feminist and other identity-based concerns, while allowing for different interpretations and applications in different cultures. In the development of contemporary philosophy, as in everyday life, ethical deliberation often involves a dynamic interplay between the universal and the particular.

RETROSPECT

The two major tasks of this chapter have been to introduce readers to a range of influential ethical theories and to discuss a number of widely accepted moral principles. One aim in performing these tasks was to make it easier to follow the arguments and discussions in the first eleven chapters of this book.

Another, and ultimately more serious, aim has been to call attention to ethical approaches that readers may wish to consider adopting in their own moral deliberations. In this regard, the problems raised in the Social Context and Case Presentations may be taken as opportunities to test competing theories and principles. You may find that

some of the theories that we have discussed here are inadequate to handle complex biomedical issues, although they may seem satisfactory in simpler and more familiar cases. Or you may discover that some commonly accepted moral principles produce contradictory results or conclusions that are difficult to accept. Other theories or principles may appear to give definite and persuasive answers to medical–moral problems, but you may find that they rest on unacceptable premises. Such a dialectical process of claims and criticism is slow and frustrating. Yet it offers the best hope of settling on theories and principles that we can accept with confidence and employ without misgivings.

During the last half century, considerable effort has been devoted to the moral problems of medical practice and research. Without question, bioethics has made genuine progress in analyzing a number of pivotal issues and securing agreement about how they should be handled. Nevertheless, a large number of moral issues in medicine remain unsettled or even unexplored. In the absence of moral consensus on these issues, we continue to face the urgent demands of everyday medical decision-making.

Under these circumstances, we cannot attempt to resolve all doubts about moral principles and only then apply them to biomedical problems. The dialectical process must be made practical. We must formulate and test theories at the same time as we try to answer urgent moral questions. We must do our best to discover the principles of aerodynamics while staying aloft.

To a considerable extent, that is the continuing ambition of this book. Medical research and practice is an area in which there are still many more legitimate ethical questions than satisfactory answers. But the growth of the bioethics movement has helped ensure that the answers that we do have are better supported and better reasoned than those available a half century ago.