

A Comparison of Approaches to Virtue for Nursing Ethics

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ABSTRACT. As in many other fields of practical ethics, virtue ethics is increasingly of interest within nursing ethics. Nevertheless, the virtue ethics literature in nursing ethics remains relatively small and underdeveloped. This article aims to categorize which broad theoretical approaches to virtue have been taken, to undertake some initial comparative assessment of their relative merits given the peculiar ethical dilemmas facing nurse practitioners, and to highlight the problem areas for virtue ethics in the nursing context. We find the most common approaches fall into *care approaches* grounded in sentimentalist or feminist ethics, *eudaimonist* approaches grounded in neo-Aristotelianism, and those grounded in MacIntyre's *practice theory*. Our initial assessment is that the *eudaimonist approach* fares best in terms of merit and relative to criticisms of virtue ethics. But an outstanding issue concerns the motivational psychology of virtuous nursing and whether virtue ethical accounts of right action are self-effacing, i.e. justify an act on grounds that cannot function as the agent's reason for doing it if she is to act well. One of us, Newham, believes that a *virtue consequentialist approach* is the best response to these issues. Some form of pluralistic theory, such as Christine Swanton's, may be needed to explain the many competing values and goods involved in ethical nursing.

KEYWORDS. Nursing ethics, virtue ethics, eudaimonism, care ethics, pluralism

I. INTRODUCTION

As in many other areas of practical ethics, virtue ethics is increasingly of interest within nursing ethics (Tschudin 2010). For the 50 year period 1950 to 2000, a search using terms 'virtue ethics' and 'nursing' returns 143 results, while a search of the 18 year period 2001 to the present returns a full 220.¹ This marks a significant change from the time

when deontological principle-based ethics and, to a lesser extent, consequentialist considerations, ruled the day.

Nevertheless literature on the virtues in nursing ethics remains relatively small and underdeveloped compared to the virtues literature in related fields, such as education or business.² Various positions have been staked out, including those deriving from care theoretical perspectives, MacIntyrean thinking, and Aristotelian *eudaimonistic* perspectives, but little work has been done comparing them (for an outstanding exception, see Armstrong 2007).

The present contribution discusses the existing literature with a few primary aims. The first is to categorize the broad theoretical approaches to virtue that have been taken and analytically elaborate them. The second is to undertake an initial comparative assessment of their relative merits, given the peculiar ethical dilemmas facing nurses. The hope (and third aim) is that this discussion will highlight problem areas for virtue ethics in the nursing context and attract the interest of more disciplinary ethicists to the field.

To briefly summarize our discussion, the most common approaches fall into three broad sorts: *care approaches* grounded in sentimentalist or feminist care ethics, *endaemonist* approaches grounded in neo-Aristotelianism, and those grounded in MacIntyre's (1984) *practice theory*. Our initial assessment is that the *endaemonist approach* fares the best of the three, in terms of merit and relative to criticisms of virtue ethics. But an outstanding issue concerns the motivational psychology of virtuous nurses and whether virtue ethical accounts of right action are self-effacing, i.e. justify an act on grounds that cannot function as the agent's reason for doing it if she is to act well. One of us (Newham 2015) believes that a *virtue consequentialist approach* is the best response to these issues. Some variant of Christine Swanton's *pluralistic virtue ethics* (2003) is a further option advocates of nursing virtue ethics have yet to explore.

Our discussion proceeds as follows. Section II elaborates some assumptions we will make about the shared, core components of virtue

ethics and how they have been taken up in the nursing ethics literature. Section III discusses why virtue ethics has been of interest in nursing ethics. In Section IV, some doubts are sown about virtue ethics for nursing followed by a critique of the various accounts of virtue ethics in the nursing literature. In the final section it is argued that a greater focus on Aristotle's account of virtue ethics may answer most of the objections to a virtue ethics in nursing. The objection that remains leaves things somewhat open between a virtue ethics based on Aristotle and a virtue ethics based on a sophisticated account of Mill as best suited for nursing.

II. SOME ASSUMPTIONS ABOUT VIRTUE ETHICS

Virtue ethics is commonly understood as the distinctive approach to ethical theorizing in which virtues or virtue concepts play a foundational explanatory role (Baron *et al.* 1997). How should we live? And what is the right thing to do? Virtue ethicists ultimately answer such questions by reference to virtue or virtue concepts. The best ways of life are virtuous ways because they are virtuous; we do the right thing, when we do, because what we do conforms to or reveals virtue in some sense. In this way virtue ethics is distinct from act ethics or an ethics of principles, such as utilitarianism or Kantian ethics, in which both right action and virtue concepts are explained by reference to putatively more fundamental moral principles or rules.

Apart from this fundamental commitment, virtue ethical theories form a broad category encompassing a range of different views. *Agent-based* or *sentimentalist* theories, such as Michael Slote's, identify the virtues with fundamentally praiseworthy motives, such as empathy or care, and explain right action in terms of these motives (Slote 2007; 2001); this purportedly distinguishes Slote's account from a similar but normative theory of care ethics based on 'social *relations* and social practices' by Held (2006), Neo-Aristotelian or *eudaimonistic* approaches, like Rosalind Hursthouse's or Philippa Foot's identify the virtues with traits that enable us to

flourish as human (Foot 2001; Hursthouse 1999). Other *practice approaches*, such as Alistair MacIntyre's (1984 – though MacIntyre himself does not claim to be a virtue ethicist), identify the virtues with the skills and qualities that enable the achievement of goods internal to the practices we engage in and goods of excellence. Still others, like Christine Swanton's *pluralistic virtue ethics* (2003), mix elements of these, identifying the virtues with qualities that are admirable for any of these reasons, and right acts with those that 'hit the target' of whatever virtues are relevant to the circumstances (e.g. if circumstances of danger, then courage or fortitude; if of trust, then honesty or loyalty; and so on). Finally *virtue consequentialists*, such as Julia Driver (2001), argue that the virtues are simply whatever traits lead us to act in utility maximizing ways.

Buried within these differences are additional differences about other important issues, such as the nature and importance of *phronesis* or the intellectual virtue of wise practical judgment (Russell 2009; Kristjánsson 2015). Some – including some in nursing ethics (Armstrong 2006; 2007) – endorse a radically particularist, perceptual conception in which wise practical judgment arises through emotional-perceptual processes in which the person of virtue, being intellectually and emotionally constituted to experience the world a certain way, just 'sees' the right thing to do (McDowell 1979). Others endorse a more generalist, cognitive model in which wise practical judgment arises at least partly through processes involving reasoning from general principles (Curren 2000).

It is hotly controversial which approach to virtue ethics is best. Each has certain theoretical merits and liabilities as a nursing ethics, the most central of which we discuss below. The broad approach, however, does share certain attractions, such as an emphasis on the moral importance of the intentions and character with which moral agents act, while being subject to certain perennial criticisms, such as providing circular or self-effacing criteria of right action. These issues are particularly relevant to thinking about the value of virtue ethical thinking for nursing ethics and we finish this section with a brief discussion of them.

By grounding ethics in character and character concepts, virtue ethics captures the sentiment that whether we act well or rightly at least partly depends on whether we act from laudatory inner states, e.g. from benevolence or from empathic distress. If I visit a friend in the hospital not from friendship or love but from duty, I act wrongly (Stocker 1976). Similarly, nursing ethicists, and particularly advocates of an ethics of care, have argued that good nurses *must* act from certain caring dispositions (Gastmans 1999; 2006; van Hooft 1999).

Virtue ethical thinking about right action also reflects the sentiment that moral dilemmas often involve making subtle trade-offs between competing values, such as autonomy and benevolence. A principle such as Hursthouse's (the right thing to do is whatever the virtuous person would characteristically do) is intentionally vague, implicitly acknowledging that a virtuous person will often have different reasons for acting at different times, e.g. sometimes to respect the autonomy of persons, other times to protect wellbeing even at some cost to autonomy. The virtues each constitute a 'rule' giving us reasons to, for example, be just, be courageous, be friendly, that must be weighed against each other in deciding what to do, and no standard method of weighing them for all circumstances exists. Similarly nursing and medical ethicists – like much of theoretical ethics generally – have by and large given up on seeking a grand principle that can guide decision-making for all medical dilemmas, preferring instead to think in terms of the virtues (Armstrong 2007; Sellman 2011) or multiple fundamental principles, such as Beauchamp and Childress's four principles model (2012).

Virtue ethical thinking is not without its difficulties as a nursing ethics. As we will see below, ethicists vehemently disagree about the moral importance of certain altruistic motivations to virtuous nursing practice, and about caring motivation in particular. Moreover the considerations relevant to resolving this dispute seem to have had as much to do with the *consequences* for nurses and patients when nurses care about their patients – for example whether caring nurses suffer debilitating burn out

– as with the inherent moral importance of caring as a nursing virtue. At the same time, principles of right action like Hursthouse’s have known vulnerabilities to counterexample and have been accused of being self-effacing. Most of us fall short of virtue, so that what it is right for the virtuous agent to do may not be right for us, because, for example, we cannot do what she would do with the requisite courage, empathy, or graciousness (Johnson 2003). On the other hand, just as we cannot be virtuous if we visit our bedridden friend from duty rather than love, nurses cannot be virtuous if their reason for caring for the patients, for example, is that this is what the virtuous person would do (Keller 2007). Virtue ethics threatens to be self-effacing in that it is impossible for us to act well if our reason for doing what we do is just that it is what virtue requires.

We will argue below that caring motivation is much less important to nursing virtue than is sometimes thought, and the reasons for this concern matters for nurse and patient flourishing. The right understanding of the sort of motives that drive good nurses has to do with the actual flourishing of the patient; notably the relief of suffering and so an attitude or motive of benevolence (Newham 2015). Similarly, solutions to the problem of self-effacingness may be in the offing, and it is hardly clear how important this problem is to the merits of virtue ethics as a framework for nursing ethics.

III. WHY THE RECENT INTEREST IN VIRTUE ETHICS?

At least two considerations make sense of the rise in interest in virtue ethics in nursing. On the one hand, nurses often face difficult situations in which they must choose between, say, comforting a patient or upsetting her with the truth; or between respecting a patient’s wishes or the wishes of her family; or between doing what seems best for a comatose patient without an advance directive or what a loved one wants done. It is clear that in such circumstances we want nurses who are wise and

compassionate, but it is not always clear how principles such as the categorical imperative or the principle of utility apply. Applying them well, moreover, might involve an exercise of practical judgment, for which there is a virtue, *phronesis* that can largely be taught to nurses (Begley 2006) and some evidence suggests good or expert nurses use practical wisdom, often labelled clinical wisdom or nursing wisdom (Farrington *et al.* 2015; Benner 1984). Further, within nursing there is strong recognition that there can and often will be moral remainder in nurses' decisions to act.

The emphasis on how to feel as well as act is important in nursing care based as it is on relationships with usually ill and vulnerable people. In numerous studies, patients look for more in a good nurse than following rules and procedures; they look for expressions of (certain) emotions some of which are virtues. Ekstrom (2012), for example, discusses a medical case study about how a lack of compassion, a fault in the agent's character, can result in poor medical treatment and disastrous outcomes. Hence, while moral rules may play an important part of nursing ethics, nursing ethicists have increasingly held that nurses need to be able to think in terms of the virtues to act well in clinical practice. They need to possess the moral perception, moral sensitivity, and moral imagination and feeling of caring and practically wise persons (Armstrong 2006; Begley 2006; Scott 2000).

The second consideration has to do with commentary and investigations into recent disclosures of bad practice. For example, the mid-Staffordshire NHS Foundation Trust enquiry (Francis 2013) and the Department of Health's 2012 vision for nursing suggest there needs be a focus on nurses good character as virtues, especially compassion. There is an implicit assumption that emphasis on developing and being educated for good character will either ensure good behaviour or at least ensure (some) motivation to behave well, at least more so than a list of rules and principles because in part the motivation is 'internal' to the nurse rather than externally imposed rules. Nursing as a professional practice involves a commitment beyond following the rules of the practice or moral rules and the

virtues will be essential in helping to prevent the corruption of such practices and more besides (Sellman 2000; 2011). However, it is noted in the nursing ethics literature that virtues are not sufficient for a good life, but nor is any moral theory, and when external circumstances are bad enough virtues might ‘harm’ rather than benefit the nurse. Virtue ethics as well as recognizing external constraints on nurses’ moral action with resultant concerns – such as moral distress and ‘burn out’ – encourages a political agenda for the profession of nursing (Allmark 2013).

The relationship between these two reasons for the recent interest in virtue ethics for nursing is that work in the former, philosophical set of concerns will provide the tools to resolve problems in the latter. But it can do so in two distinct ways only one of which reflects the notion of virtue ethics as a distinct theory. Currently scholars disagree in their approach, however, some developing models derived from Rosalind Hursthouse’s *eudaimonist model* (Armstrong 2007), others developing models deriving from Alastair MacIntyre’s *practice model* (Sellman 2011), and still other models merging virtue ethics to an ethics of care (Gastmans 1999; van Hooft 1999). We review examples of these different approaches in sections IV and V below, drawing attention to the central virtues of each approach, especially the nature and respective place of virtues of care or benevolence, on the one hand, and judgment or wisdom on the other.

IV. DOUBTS ABOUT A VIRTUE ETHICAL APPROACH TO NURSING ETHICS

While a virtue ethical approach to nursing ethics is clearly in the ascendancy, it is not without its critics. For some a virtue ethical approach is neither needed for identifying the virtues of nurses nor particularly useful for helping nurses resolve the dilemmas they face (Holland 2012; 2010). For others virtue ethics is at best supplemental to rule and code-based approaches (Salsberry 1992) or it fails to plausibly explain the normative basis of the nursing virtues (Newham 2015).

In an early critique, Salsberry argues that virtue theory is not an adequate complete replacement for ethics of duty (1992). An adequate, stand-alone theory of ethics for nursing must (possibly among other things) “[...] accommodate a relational basis of nursing practice; recognise the contextual nature of ethical decisions; and be concerned with the development of persons” (1992, 157). As she understands it, virtue ethics is the idea that persons and their virtues are the locus of moral assessment. She follows MacIntyre in defining the virtues as characteristics needed to realise goods internal to practices and “[...] sustain us in the [...] quest for the good” (1992, 161). And for the practice of nursing she follows some care theorists in claiming that the central virtue is care and that, “Questions of right or wrong, good or bad, are no longer relevant. Certain virtues are cultivated because of their relation to caring and one cares because of a natural sentiment, not because it fulfills an obligation or duty of practice” (1992, 161).

Salsberry denies that this theory is an adequate standalone replacement for an ethics of duty. By making a place in nursing ethics for care, it does a better job of comprehending the relational basis of nursing. But it does not adequately settle the question of which virtues are important to nursing – apart from the virtues of justice, courage, and honesty that sustain all practices – since nurses play many different roles. In abandoning principles and consideration of what’s right or wrong, it is perhaps less abstract, but may lead to wrong conduct, she thinks, as nurses permit themselves to simply fall back on their peculiar sensibilities or judgment.

Perhaps extending Salsberry’s critique, Holland (2010; 2012) argues that we do not need virtue ethics to tell us to be virtuous or to know that, for example, kindness and honesty are virtues for nurses. For that we have utilitarianism or Kantianism, which respectively tell us to be beneficent and treat others as ends in themselves. The teleological structure of virtue ethics also adds nothing helpful, he thinks, to our understanding of the virtues of nurses; that the virtues serve the human *telos* tells us nothing about ethics in the context of nursing particularly and “obliterates the personal-professional distinction” (Holland 2010, 157). Various ways

of fixing this problem do not work, including positing a *telos* for nursing, or moving to a MacIntyrean account in which the nursing virtues are those needed for the realisation of goods internal to nursing as a practice. The former tack does not work because the *telos* of healthcare institutions is arguably something like “[...] the furtherance of health as a human right” and this, he claims, is a mixed utilitarian-human rights value. The latter does not work because it “[...] either reduces the complex of ethical resources available to a nurse, or misleadingly recasts them in virtue ethical language” (2010, 158). Furthermore, virtue ethics cannot accommodate role-specific obligations because these can sometimes conflict with general human virtue, e.g. a defence lawyer withholding incriminating information. Looking to the *ergon idion*, i.e. or defining function of the institutions in which our roles are grounded, as a virtue ethicist might, he argues, is no help. Understanding this only helps us understand the grounding of role-specific duties, not whether we ought to prioritize those duties over the demands of general human virtue.

A third worry (that one of us has very recently advanced) argues that virtue ethics is not a plausible standalone approach to nursing ethics (Newham 2015). A virtue ethics is supposed to be an explanatory theory – seeking to explain why when an act is right in terms of the character of the agent – and not merely ‘substantive’ or indicative of what our obligations are. But it is hard to see how this can be as even a *phronimos* will have reasons for doing what she does that are not about her character, not of the form “Because it would be virtuous of me” (Newham 2015, 47). For his part, Newham maintains that in the nursing domain such questions of justification are usually relatively uncontroversial as “Most, if not all, of what nursing practice entails is achieving good outcomes for patients” (Newham 2015, 49). In general:

How a nurse should be to nurse well or excellently is to be someone who recognises suffering and does something to relieve it. Suffering is the normative term and...While character and virtues are important, they are so because they seem to reliably lead to good effects (Newham 2015, 49).

For this reason Newham (2015) favours a shift to *virtue consequentialism*, or the view that ethical controversies – including practical questions nurses face about what they should do and why, as well as theoretical questions about why, for example, benevolence, trustworthiness, etc. are virtues – are to be resolved by references to what produces good outcomes. In Newham’s view, “What makes an action good and what makes a trait of character a virtue [...] is the good effects it produces” (2015, 49).

Finally, one common criticism of virtue ethics generally has relevance in the nursing context. This is that by directing our attention to the virtuous character of the individual, virtue ethics neglects the significance of the social environment.³ Substantial evidence exists demonstrating that even well-meaning nurses, those who are otherwise good people, can act badly in a ‘blocking’ context, one that makes it exceedingly difficult, costly, or stressful to see the right thing to do, or to do it in the workplace. These include case studies such as the mid-Staffordshire scandal, the broader ‘situationist’ literature in social and moral psychology, and the literature concerning the effects of phenomena such as ‘compassion fatigue’ on nurse morale and conduct (Austin *et al.* 2009).

Thus nursing virtue ethics has been subject to numerous serious criticisms. To summarize and distil:

- i. It is not an adequate standalone replacement for an ethics of principles because it does not adequately settle the question of which virtues are important to nursing and may lead to wrong conduct (as it leaves nurses to make judgments out of natural sentiments of care rather than from principles).
- ii. It is unnecessary because utilitarian and Kantian principles already reveal the relevant virtues for nurses and it offers no guidance on how nurses should resolve conflicts between their professional obligations and their obligations as humans.
- iii. It misrepresents the practical reasoning of wise nurses (the sorts of reasons wise nurses have for making decisions) and over-estimates the importance of good motivations in nurses (what matters is securing good outcomes for patients).
- iv. It gives too little weight to the social context for thinking about how to support the ethical practice of nursing.

V. APPROACHES TO NURSING VIRTUE ETHICS

Whether and how advocates of nursing virtue ethics can respond to such criticisms depends partly on the shape of the best approach to take for this field of work. As we mentioned above, three broad approaches have been taken in the current literature; care approaches, MacIntyrean practice theories, and *endaimonist* approaches. In this section we critically discuss each of these, arguing that a *endaimonist* approach has the most going for it at present.

Care Approaches

Nursing is a caring profession *par excellence* and nearly every writer on nursing ethics agrees that care in some sense is central to good nursing (recognizing that for some the emphasis is on a relationship). But the precise sense in which good nurses care is controversial. Do caring nurses actively involve themselves emotionally in the fates of their patients, akin to the way they involve themselves emotionally in family members or friends, so that “[...] they allow themselves to be touched by what happens to the patient” (Gastmans 1999, 217)? Or do they merely treat patients in caring ways but not care in this partial sense (Armstrong 2007; Curzer 1993)?

Let us call those who take the first view advocates of the *caring attitude position* and those who take the second view advocates of the *caring behaviour position*. In an earlier articulation of his view (we discuss some more recent work below), Chris Gastmans once seemed to advance a form of the first view. Defining the caring moral attitude “[...] as a sensitive and supportive response of the nurse to the situation and circumstances of a vulnerable human being who is in need of help” (1999, 216), Gastmans claimed that the nurse who cares in this way will “adopt a vulnerable position,” “allow themselves to be touched by what happens to the patient,” have “real and lasting involvement with the patient,” “identify

with patients’ pain and suffering” and “desire to do everything possible to relieve the patients’ situation” (1999, 217). Care in this sense is a primary moral responsibility of nurses because it is only through such caring that “nurses express [...] that the patient is of value to them” and “endow a sick human being with a moral value” (1999, 218). Caring is a virtue that imbues caring actions with moral value by communicating moral respect and concern for the patient.

This account of what constitutes care as a distinctive character trait gels with certain traditional commitments of broader care ethical and sentimentalist virtue theorizing. Alongside early advocates of a virtue ethics, care ethicists have maintained that partiality in moral concern, i.e. prioritizing the well-being of those we care about, is not only acceptable, but sometimes required. Placing partial concern at the centre of caring motivation also distinguishes the (putative) virtue of care from emotions like compassion or behaviours like universal benevolence with which it might be confused (but with which it could not be identical, since virtues are dispositions to whole suites of feelings, behaviours, and motivations). It also constructs this virtue consistently with a sentimentalist understanding of the normativity of good character; virtuous traits of character are virtues because they involve inner states, motives especially, toward which we have approving feelings. In these ways, the caring attitude view constitutes a distinctly sentimentalist, care theoretical form a nursing virtue ethics might take.

The ‘caring attitude’ position has come in for some serious criticism, however. Defining care similarly – as not merely ministering to patients in a caring way, but to have a liking for them or an emotional investment in their wellbeing – Curzer (1993) flatly denies that care so construed is a virtue for health care professionals (HCPs). In his view, emotional involvement with patients interferes with all sorts of things HCPs ought to do in their role as HCPs. These include ministering to all their patients impartially, maintaining objectivity in their decision-making, and avoiding paternalistic treatment of their patients (e.g. deceiving them for their own

good). It also promotes burnout, which reduces the quality of care, ironically by reducing the capacity to treat people in caring ways. Curzer concludes that HCPs should treat patients in caring ways but not care (for them), so that the relevant virtue for HCPs is not care but benevolence, i.e. caring behaviour without the emotional attachment to individuals.

Recent literature has tended to take the side of the caring behaviour position and defences of specifically care-based nursing virtue ethics are increasingly few and far between (Leget *et al.* 2019). Indeed some of Gastmans' most recent work attempts to provide a normative ground for care ethics and whilst it can be applied to nursing it is not about nursing virtue (Vanlaere and Gastmans 2011). A few considerations seem to favour this trend. First, while nurses surely do have a responsibility to show that they value their patients as moral persons, it is hardly clear that they can do so only by forming partial attachments to them. Indeed the traditional view is that moral respect, particularly between non-intimates, requires a certain amount of impartial regard for all persons rather than partial attachment to any in particular (Darwall 1977; Swanton 2003, chapter 5). As Curzer argues, this seems to apply just as well to nursing as to ordinary daily life. Gastmans' early work simply assumes that patients will experience a nurse's emotional bond to them as an expression of their moral worth. But an argument is needed here. Why not think that many patients will experience this as highly unusual, perhaps intrusive? Why assume that patients will feel disrespected if their nurses are merely benevolent and simply act *as if* they care?⁴

Perhaps in response to such doubts, Gastmans denies in later work that a virtue of care for nurses involves such partial emotional investment in the well-being of patients (2006). The “bearers of the virtue of care” will differ from “the bearers of positive personal feelings” in that the “motivational strength to continue a benevolent engagement is much stronger in someone who possesses the caring virtue than in a person who simply maintains an emotional link with someone based on positive experiences” (Gastmans 2006, 140). Nurses “find motivation for their

caring behaviour [instead] by being involved in the well-being of patients” and not in “various personal features of the person who they experience as pleasant” (2006, 140). Thus:

Caring behaviour is not mainly concerned with personal affective attraction to people, enjoying their presence, being drawn to them, and so forth. Much more important is that caring behaviour is motivated by the actual situation in which the other finds himself or herself, or in his or her well-being (Gastmans 2006, 140).

In this way it is quite possible for nurses to be motivated to help patients whom they do not particularly like or with whom they do not become emotionally involved.

These stipulations concerning the emotions proper to a virtue of care resolve the difficulties concerning the caring attitude version of this approach. Indeed, they appear to be designed specifically for the purpose of doing so and in this respect appear to be *ad hoc*. Because they revise the view in the direction of the caring behaviour position, they also have the effect, at best, of obscuring the meaning of care relative to concepts such as compassion, benevolence and the like. At worst, they simply conflate the virtue of care with ordinary universal benevolence, i.e. impartial helping behaviour for suffering persons, motivated by normal human concern, empathy, or sympathy, perhaps mixed together with some common professionalism.⁵

In addition to moving toward a caring behaviour view, Gastmans has also insisted that “[...] conceptualizing care as a virtue does not necessarily lead to envisioning care ethics as virtue ethics.” Instead, “[...] care ethics is more a stance from which we can theorize ethically rather than a full-blown ethical theory in itself” (2006, 146). Confusingly, however, Gastmans, in the same essay (2006) also joins Stan van Hooft (1999) in provocatively claiming that “care as a virtue” – far from being a necessary but insufficient basis for ethical thinking independently of “principle-based ethical thinking” – “[...] encompasses all aspects of moral

behaviour, that is, the emotions, motivations, knowledge and ethical reasoning itself” (Gastmans 2006, 145). The “virtue of care is an ethical orientation of the individual” that thus “encompasses [...] the nurse who is concerned about doing the right thing, with the right degree of sensitivity, with the right knowledge and skills, at the right time” (2006, 145).

These claims are not clearly consistent with each other, nor independently helpful. The first abandons the project of developing a care theoretical approach as a distinctive virtue ethics for nursing. The second claims that nurses having a single moral orientation, properly described as the virtue of care, have what Aristotelians would call ‘full virtue’ within the domain of nursing ethics, i.e. they would have all the virtues needed for wanting to act well as nurses and for reliably, successfully doing so. As van Hooft puts it: “Acting from caring, or acting well in the health care context, involves sensitive awareness, proper motivation, and rational, evaluative judgment. Accordingly, being a caring health care worker is enough to ensure that one will act well” (1999, 200).

The first claim is not helpful to the cause of care approaches to nursing virtue ethics for (hopefully) obvious trivial reasons. The second is helpful, if true. But given everything just discussed, it is difficult to see how it could be true in anything but a tautological sense. In this way of understanding the virtue of care, ‘care’ is a simply an umbrella under which the altruistic (and also, since the virtue of care encompasses everything, evidently the self-interested) beliefs, motives, or feelings of virtuous nurses are pulled. These then themselves do the hard work of constituting the moral orientation through which virtuous nurses act well. Redefining ‘care’ to mean *phronesis*, or practical judgment, (without quite explicitly saying so) might well guarantee that those having it will act well. But that will be because they possess and have managed to harmonize many other dispositions besides those commonly dubbed care, such as fairness, courage, trustworthiness, honesty and so on.

It is important for sure for nurse practitioners and scholars to think through what it means to be caring in their practice. The scholarly

conversation about the virtue of nursing has advanced that end greatly by running through many senses in which care might be a virtue (even *the* virtue) for good nurses. But for the reasons just elaborated, it seems unlikely that care *per se* is a virtue of good nurses rather than a cipher for impartial benevolence, compassion, professionalism, and other related dispositions, feelings, or virtues working together.

MacIntyrean Practice Approaches

While the literature in virtue ethics for nursing remains quite small compared to other fields, two major books have been published in the past eight years: Derek Sellman's *What Makes a Good Nurse* (2011) and Alan E. Armstrong's *Nursing Ethics: A Virtue Based Approach* (2007). Both books are free of the conflation plugging care ethical formulations of a virtue ethics for nursing, Armstrong explicitly endorsing compassion over care as the relevant virtue of nurses (2007, 139; Sellman is more silent on the matter but does not commit himself to care). Both also contain comprehensive coverage of a large range of topics, from the essential differences between virtue and act ethics, the nature of patient vulnerability, the role of the nurse and nursing practice, situationist and other criticisms of virtue ethics, and specific virtues such as trustworthiness and practical judgment.

Many points of agreement emerge. Both endorse a holistic, helping model of the nurse patient-relationship and understand patients as particularly vulnerable persons having broader interests than medical treatment of the body (Armstrong 2007, chapter 2; Sellman 2011, chapter 2). For both, this means that the role of the nurse is considerably broader than administration of medicines, taking vitals, and the like and calls for moral virtues like honesty, trustworthiness, courage, justice and practical wisdom (Armstrong) or 'professional *phronesis*' (Sellman). They disagree, however, on the normative grounding of these virtues, i.e. on the ultimate reason why these qualities are virtues for nurses, and consequently disagree at the margins on important substantive matters. Sellman appeals

to the nature of nursing practice and to the (putative) goods nurses can achieve by engaging in that practice well, whereas Armstrong appeals to the role of a helping nurse-patient relationship in promoting patient flourishing.

For Sellman, nursing is a practice in MacIntyre’s sense, a form of activity through which virtuous nurses can achieve certain distinctive goods of the practice and advance their own well-being and the well-being of their patients. Nursing *is* a technical enterprise requiring nurses to possess certain intellectual virtues and skills, especially the open-mindedness needed to stay abreast of new techniques and carefully balance new evidence against received wisdom, protocols, institutional procedures and so on (2011, chapter 5). But it is not well regarded as a science because it is “[...] not primarily concerned with describing phenomena.” Rather it is “[...] a practical activity with normative and evaluative ends” (2011, 97). Its excellences include:

[...] the provision of a high standard of nursing care however this is defined within a particular interaction between nurse(s) and patient(s). The internal goods associated with the pursuit of this ideal might include the professional satisfaction of a job well done and pleasure at the attempt of making a positive difference to the well-being of the patient (2011, 103-104).

Because it often involves having to decide between competing moral claims or interests, nursing practice especially requires the use of professional *phronesis*, or “[...] the ability for an individual nurse to aim at doing the right thing with (or to) the right patient at the right time in the right way for the right reasons” (2011, 39). But nurses also need the core virtues said to sustain practices, including justice, honesty, and courage.

Armstrong is sceptical that the virtues of many practices are established by reference to goods internal to the practice. This may be true for self-contained practices, like chess, but is arguably not the case for ‘purposive practices’ like farming or medicine, which serve broader social

goods. For these practices, standards of excellence derive more from the broader social aims they serve, which in turn are valued primarily for the role they play in facilitating social cooperation and human flourishing.

Though he does not address Armstrong’s view directly, Sellman is aware of the criticisms of a MacIntyrean approach to the virtues in nursing. For his part, the question whether nursing is or is not a practice is a red herring since it is “[...] the similarities in terms of the potential for internal goods that contribute to human flourishing within practices that is important rather than any attempt to categorise practices on the basis of dissimilarities” (2011, 84). Furthermore, “[...] many nurses [...] will find meaning in the idea of nursing as a practice precisely because it offers the potential for the nature of nursing to be captured in a rich conceptualization which many find absent in existing accounts” (2011, 86).

These claims are not terribly helpful for advocates of MacIntyrean approaches to nursing virtues, however. Precisely what is at question is whether the idea of internal goods contributing to flourishing can advance our understanding of the fundamental features of nursing as a practice. Alas, the putative internal goods Sellman and Armstrong identify – the satisfaction of a job well done, pleasure at the attempt to make a positive difference in the life of another, and so on – do little to nothing to characterize nursing as practice in particular and are not in that sense internal to it.

The Eudaimonist Approach

Alan Armstrong argues that good nurses possess many of the same virtues, as those proposed by Sellman including a virtue of practical wisdom. Following Hursthouse, Armstrong argues that nurses frequently face many difficult dilemmas, some of which cannot be straightforwardly resolved, at least not without “moral remainder” (2007, 46). Deciding whether, for example, to lie to a patient who survived a car crash that killed the rest of her immediate family, will require the exercise of judgment and leave a residue of moral regret arising from the impossibility of satisfying every

morally relevant principle. Armstrong also takes on board certain MacIntyrean ideas, maintaining that attending to patients' narratives is important to achieving a helping nurse-patient relationship and that traditions of enquiry provide the terms that establish the meaning of narratives.

For Armstrong, nursing is a purposive practice that serves the aim of protecting or restoring the wellbeing of patients, people who are suffering from a range of special vulnerabilities. At best nursing has somewhat obscure internal goods involving “[...] positive emotions that one feels, the praise and admiration from others and the memorable sense of achievement one gains from acting well” (2007, 186). These goods are not uniquely available to nurses and what goods there are must be achieved “[...] through the development and sustenance of a virtue-based helping relationship” (2007, 86). The nature of this relationship and its role in protecting and promoting patient flourishing sets the virtues of nurses. For Armstrong, this relationship is such that three classes of virtues seem to be especially important in addition to practical wisdom, including helping virtues like compassion, advocacy virtues like courage, and empowerment virtues like trustworthiness (2007, chapter 8).

For this reason Armstrong follows thinkers like Hursthouse in defining the moral virtues as “[...] morally excellent character traits that help people to lead morally good lives and [that] deserve praise and admiration from others” (2007, 35). Virtue is not necessarily knowledge; someone could know a great deal about justice but be unjust, and the virtues we each need is partly determined by role and their meaning might differ in different eras (e.g. modesty is different in Victorian England than in contemporary England). But, Armstrong argues, “[...] it is plausible to suggest that moral virtues such as trustworthiness...are important in meeting [human] needs” (2007, 34). In general the virtues are valuable because “virtues are important in human lives” (2007, 36), i.e. people need the virtues in order to get on with each other.

Our best understanding of the nature of nursing seems to derive primarily from our understanding of a holistic, helping nurse-patient

relationship and its role in promoting the fundamental external end of nursing, namely the total emotional, physical, and spiritual wellbeing of the patient. To that extent, there is little to be gained from the attempt to understand the virtues of good nurses through a MacIntyrean lens.

That said, Sellman quite rightly points out that nurses are vulnerable people too (2011, 71). However the nurse-patient relationship is understood, the demands of excellence in nursing must be consistent with protecting the flourishing of nurses themselves. The goods nurses can achieve through their work, whether internal or otherwise, have some role to play in determining those demands. A grasp of the history of nursing can be helpful, too. But perhaps most important are considerations such as those behind Curzer's opposition to care as a virtue and which flow simply from reflection on the limits of what nurses can do to help others in caring ways.

* * *

We have examined three different approaches to nursing virtue ethics in this section, care approaches, MacIntyrean approaches, and *eudaimonist* approaches. We have found that the *eudaemonist* approach has the most going for it of the three. While benevolence or compassion are key virtues for nurses who would establish holistic, helping relationships to their patients, it is doubtful that care in the sense in which it is distinctive from these is not. Nurses who attend to patient's narratives may also be more likely to establish such relationships and the demands of excellence in nursing must be compatible with protecting the well-being of nurses. But it is unlikely that nurses can achieve particularly distinctive goods through moral excellence in their profession. Our understanding of the nurse's role and the virtues needed to fulfil that role is illuminated more by our understanding of the fundamental aims of nursing and its role in securing patient flourishing.

VI. THE CRITICISMS REVISITED

How does a *eudaimonist* approach fare against the criticisms that have been levelled against nursing virtue ethics? To recap, the criticisms we have identified are these: Nursing virtue ethics...

- i. Is not an adequate standalone replacement for an ethics of principles because it does not adequately settle the question of which virtues are important to nursing and may lead to wrong conduct (as it leaves nurses to make judgments out of natural sentiments of care rather than from principles).
- ii. Is unnecessary because utilitarian and Kantian principles already reveal the relevant virtues for nurses and it offers no guidance on how nurses should resolve conflicts between their professional obligations and their obligations as persons.
- iii. Misrepresents the practical reasoning of wise nurses (the sorts of reasons wise nurses have for making decisions) and over-estimates the importance of good motivations in nurses (what matters is securing good outcomes for patients).
- iv. It gives too little weight to the social context for thinking about how to support the ethical practice of nursing.

A *eudaimonist* approach, though not without its problems, we believe fares reasonably well. We discuss how a *eudaimonist* might respond to each below.

Salsberry's criticism of nursing virtue ethics does not apply to *eudaimonism*. It confuses virtue ethics with an essentially MacIntyrean theory – in which the virtues are those qualities conducive to achieving the goods internal to practice – and then develops this idea through the lens of yet a further theory, the ethics of care. As we have argued above, the relevant cardinal virtue for nurses is not care, but compassion or benevolence. And the best method to date of determining the relevant virtues for nurses turns not on understanding the role *per se* of nurses in health-care, but of holistic, helping nurse-patient relationships in protecting and promoting patient flourishing (consistent with the flourishing of the nurse). The further virtues of nurses are to be extrapolated from this

conception of the aims of nursing and this requires an analysis of flourishing, of the kinds of obstacles to flourishing patients often face, of the knowledge, techniques, and comportment of nurses who would help patients overcome such obstacles, and so on. No such analysis appears in Salsberry's critique, but analyses like Armstrong's are broadly plausible and yield an account specifying whole classes of nurse virtues. Education in such virtues and connections with the role or what it is to *be* a nurse are a part of most nursing curricula and would benefit from philosophical clarification of eudaemonist virtue ethics.

On the other hand, while it is true that for Aristotelians the virtuous person will want to do the right thing (so that the tension between what she must and what she desires to do will be reduced), it is not true that principles and reasoning about the right thing to do have no role in a *eudaimonist* framework, or that virtuous moral agents do not have to think about the right thing to do. For Aristotelian *eudaimonists* like Armstrong, because nurses must often make difficult choices between the interests of competing stakeholders to healthcare, practical wisdom is a crucial nursing virtue. But the practically wise person is one who does the right thing, at the right time, in the right way, and all the rest. It *is* controversial whether Aristotelian practical reasoning is more generalist or particularist, i.e. whether it depends upon or proceeds through reasoning involving general moral principles or through emotion and a kind of perceptual sensibility for example Armstrong (2006) advocates a strongly particularist approach for virtue ethics for nursing (Hooker and Little 2001; McDowell 1979). But generalism is consistent with the view and Aristotle's own view seems to be mixed, involving principles like the doctrine of the mean (Aristotle 1985; Kristjánsson 2015; Martinez 2011; Pettigrove 2011).⁶

It is certainly controversial whether this theory is a fully adequate replacement for an ethics of principles, or is even distinct from it. This is a controversy we do not have the space to go into here. Suffice to say that variants of this theory have become a force to be reckoned with in the philosophical literature, defended by numerous leading thinkers in

ethics (Badhwar 2014; Flanagan 2007; Kraut 2007; LeBar 2013). The charge that it is not needs substantial argumentation.

Utilitarianism and Kantianism certainly do reveal some of the relevant virtues for nurses. Nurses should be benevolent (the utilitarian's prime virtue) and they should be respectful or fair (the Kantian's prime virtue). As we have noted, however, the principles grounding these virtues can conflict and to date no consensus has emerged on how such conflicts should be resolved. For this reason *endaimonists* believe that ethical nurses will need a virtue of *phronesis* to determine what they must do when principles (or the virtues in fact) conflict. The same can be said for any putative principles we might devise for resolving conflicts between nurse's professional obligations and the obligations they have as persons.

But *phronesis* is not the only further virtue they will need. Because they may be called upon to advocate on behalf of a patient not receiving the care she needs, as Armstrong suggests, nurses may need a virtue of courage. Because they will need to stay abreast of technical developments and be ready to adopt new practices, as Sellman suggests, they will need a virtue of open-mindedness. And so on. Utilitarian and Kantian imperatives indicate only a couple of the central nursing virtues. Uncovering the others requires the richer picture provided by understanding and unpacking the aims of nursing and their role in *eudaimonia*.

Of the four critiques posed, Newham (2015) arguably raises the deepest issues. We will not be able to deal with them sufficiently here. At the heart of Newham's critique is the question whether the motives nurses have in ministering to their patients matter, in a non-instrumental sense, to their virtue. Must nurses have certain motives in order to be ethical, or is it enough if they act in ways that 'promote good outcomes for patients'?

A way into this may turn on addressing this remark that virtue ethics misrepresents the reasoning of the virtuous person, or is 'self-effacing', i.e. justifies acts on grounds that cannot supply a virtuous agent's reason if she is to act as she ought. As Newham points out, this problem emerges

for virtue ethicists if, on this view, what justifies an act is that it is what a virtuous person would do. This seems to be incorrect. Friends who visit us in hard times can do so virtuously only if they do so because they care about us, not because they believe that it is what a virtuous person would do (Keller 2007).

For this reason Newham favours a form of *virtue consequentialism* in which the what it is right for nurses to do depends upon virtues that express what will reliably produce (perhaps maximize) good outcomes for patients. In addition, for nurses and a nursing ethic, the response to the valuable outcomes must be agent neutral unlike perhaps for the agent's close personal relationships (McElwee 2015). This is unlike *eudaimonist* approaches that focus on the fully virtuous agent as the standard for right action and the broader scope of a good life as a whole especially for the virtuous person. But it is similar to *eudaemonistic* virtue ethics in that there is an objective justification of the virtues and that such a virtue ethics partly involves promoting the good of others.

A discussion of this problem is emerging in the general ethics literature (Martinez 2011; Pettigrove 2011). Whether it can be solved from a nursing ethics perspective should be an important direction for future work. For a number of reasons it is certainly an open question whether *eudaimonism* or *virtue consequentialism* is preferable on this matter, or whether another approach altogether, like Swanton's pluralistic virtue ethics can make more sense of things.

First, virtue consequentialism is also likely to be self-effacing. For the virtue consequentialist, acts and virtues alike are justified on grounds that they promote good outcomes. Utilitarian versions of this theory will be self-effacing because the imperative to always act so as to maximize collective utility cannot be the virtuous agent's motive if she is to act well in certain interpersonal contexts, particularly those where some form of partiality is called for (Stocker 1976). Other versions are very likely to be as well since any general principle of right action underlying them will justify actions on (and so direct moral agents to act for) general grounds, e.g. to

maximize collective happiness, to love the good, or whatever. Friends who visit us in dark times for these reasons are no more virtuous than virtue ethical agents.

Second, virtue consequentialists agree that motives matter for instrumental reasons. Nurses who care about their patients in the care ethical sense, for example, are more susceptible to burnout and so to producing poorer outcomes for patients. However as Curzer argues, they are also susceptible to doing things they ought not do whatever the outcomes for patients, such as show partiality to some and not others. While such partiality will often have adverse outcomes for those patients not on the receiving end of it, it is arguably wrong for nurses to be partial this way even when it does not.

If this is correct, the motives of nurses can sometimes matter whatever the further consequences for nurse behaviour and patient outcomes. But a theory of when and how they matter remains controversial and developing a theory of this is an important direction for work. *Eudaimonistic* approaches seem to do so, though not without their problems. What is lacking at present is a sufficiently pluralistic theory of right action that is not plainly self-effacing⁷ and that distinguishes flourishing ultimately from consequentialism in a way that seems plausible (Hooker 2002; Hursthouse 2002). The application and merit of Swanton's view, according to which right actions are those that 'hit the target' of virtue, may be a promising direction for future work (Swanton 2003, chapter 11).

Finally, the criticism might be made that virtue ethics, in directing our attention to what it takes for individuals to act well, neglects the importance of the social/environmental context.

The evidence that social/environmental factors can have a powerful influence on individual behaviour cannot be ignored; it is both widely confirmed and commonsensical. However, its meaning for the moral psychology of virtue is also highly contested. Virtue sceptics have argued that it demonstrates that character is a total fiction (Harman 2000) while virtue ethicists have argued that the data are compatible with what we would

expect if character plays a role in behaviour (Kristjánsson 2012). This particular aspect of the present line of critique may be moot, however, at least for present purposes; the success of ‘situationist’ criticism of character would be equally devastating for care and practice approaches to virtue as for *eudaemonist* ones, and compassion fatigue will not go away just because we choose to think like utilitarians or Kantians. In this respect all approaches to nursing ethics are partners in crime before the problem of the social environment.

However in another aspect a *eudaemonist* approach may at least hold its own against other approaches to virtue and non-virtue theories, and provide a powerful basis for a response in its own right. Whether individuals or social forces should be the focus of our attention is a false dilemma within an Aristotelian framework. As argued above, on a *eudaimonist* approach, our best understanding of the nature of nursing derives from our understanding of a holistic, helping nurse-patient relationship and its role in promoting the comprehensive wellbeing of the patient. In this way *eudaimonist* approaches to virtue necessarily direct us to think about both the constitutive features of patient wellbeing, as well as about the dynamics of a helping nurse-patient relationship. These are excellent starting points for thinking about the demands of shaping the social environment to support ethical behaviour. What ways of interacting make things go well for patients? What obstacles stand in the way of nurses acting in these ways? These are critical questions for determining both how nurses individually can act well and for extracting principles for structuring the work environment to support their doing so.

VII. CONCLUSION

Virtue ethics is being taken up more and more in discussions of nurse training and practice (Armstrong, Parsons and Barker 2000; Cooke 2015). Despite this, a great deal of work remains to be done. Not all nursing ethicists are fully convinced of the merit of the overall approach – including

one author of this article – and advocates of the approach disagree considerably about how it should be understood. Extant formulations of care based, *eudaimonist*, and MacIntyrean virtue ethical approaches also have yet to deal with some of the deeper problems for virtue ethics generally, such as the self-effacingness problem, and for virtue in the context of nursing, such as the precise nature of virtuous caring in nursing practice. If efforts to teach the virtues in nurse training are to be successful, more work on the virtues of excellent nurses is urgently needed.⁸

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NOTES

1. Search performed October 10, 2019 using all databases on PubMed.gov, <https://www.ncbi.nlm.nih.gov/pubmed>.

2. A search for ‘virtue ethics’ in the *Journal of Business Ethics* alone returns over 200 results.

3. We thank an anonymous referee for drawing our attention to this issue.

4. This last question invites an obvious counterargument: It is not possible for nurses to show moral respect without caring because it is not possible for them to act as if they care without actually caring. In the earlier essay, Gastmans endorses this argument when he claims, “No one can consciously feign this [caring] attitude” (1999, 281). However the point seems to belie two confusions in the caring attitude position, one between care ethics and virtue ethics generally, the other between partial care and concern for the well-being of particular others and universal compassion or benevolence. For many of its advocates, such as Noddings, care ethics is not a virtue ethics but an ethics of duty in which the fundamental moral obligation is to sustain relationships of mutual care (2002, 1984). This imperative does not appear in Gastmans’ view and it would be somewhat odd if it did. There is no presumption that *patients* have any such obligation, or even interest, with regard to their nurses. Nurses who make a duty of this aim to that extent misunderstand their role, or even put themselves at risk of being exploited; nurses, after all, are vulnerable people, too (Sellman 2011, 71). At the same time, while it is difficult to imagine nurses ministering care without caring in some sense, there is no obvious reason why this care cannot be grounded in a general human sympathy or compassion for suffering others and the beneficence it prompts. Indeed nurses having these virtues are likely to be ‘touched by what happens to the patient’ quite without trying. Making a goal of trying to care for each and every distinctive patient might border on masochistic and Curzer seems right to say that nurses who care in this way are in danger of quickly burning out and undermining their own efforts.

5. To elaborate, consider the definition of the virtue of care by van Hooft (1999) Gastmans draws upon in this same essay (Gastmans 2006, 139): caring is “[...] the comportment of the self towards others, which has the inherent goal of enhancing the existence of those others, whether they are others in intimate relationship to me, others for whom I have professional responsibility, or others with whom I identify simply because they are compatriots, coreligionists or fellow members of the human race” (van Hooft 1999, 190). It is possible to replace the term ‘care’ here with ‘impartial benevolence’ and lose no significant meaning. As van Hooft develops this view, the virtue of care is said to have an emotional component which involves concern for the health of others and some degree of sympathy for suffering others. Caring nurses will experience this out of a sense of professional commitment, not necessarily from “[...] a relationship of intimacy with the patient” (van Hooft 1999, 190). Again, replacing ‘care’ here with ‘impartial benevolence’ results in no loss of meaning.

6. For an account of the importance (or not) of social psychological findings for character and nursing see Paley (2013) and Derbyshire (2014).

7. However see Pettigrove (2011) for a promising approach.

8. Generous support for this research was provided by The Jubilee Centre for Character and Virtues. The authors would also like to thank Kristján Kristjánsson, two anonymous referees for this journal, and Brian Doyle for helpful suggestions and feedback on earlier drafts of this paper.