



GUILTY BUT GOOD: DEFENDING VOLUNTARY ACTIVE EUTHANASIA FROM A VIRTUE PERSPECTIVE

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This article is presented as a defence of voluntary active euthanasia from a virtue perspective and it is written with the objective of generating debate and challenging the assumption that killing is necessarily vicious in all circumstances. Practitioners are often torn between acting from virtue and acting from duty. In the case presented the physician was governed by compassion and this illustrates how good people may have the courage to sacrifice their own security in the interests of virtue. The doctor's action created huge tensions for the nurse, who was governed by the code of conduct and relevant laws. Appraising active euthanasia from a virtue perspective can offer a more compassionate approach to the predicament of practitioners and clients. The tensions arising from the virtue versus rules debate generates irreconcilable difficulties for nurses. A shift towards virtue would help to resolve this problem and support the call for a change in the law. The controversial nature of this position is acknowledged. The argument is put forward on the understanding that many practitioners will not agree with the conclusions reached.

Introduction

In a virtue ethic, lying, stealing and killing, for example, are not wrong because some general principle or rule claims that they are wrong. Virtue ethics denies the claims that the moral person is necessarily governed by a concept of duty, and that good conduct is necessarily presented to us in the form of general rules and principles.¹ Instead, virtue ethics emphasizes the Aristotelian and Thomistic belief that morality and the self are inseparable, or intertwined.² Ethics in nursing does not simply come into play when a decision has to be made; it is integral to everyday life and practice. Every encounter with patients and colleagues is a moral encounter and clients are not passive recipients of our moral endeavour. They are, if able, active partners with responsibilities and there is a balance between the needs and aspirations of

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nurses and clients. Flourishing is therefore a two-way process in which professionals and clients are working in partnership towards a goal of health and well-being.

Definition of a virtuous nurse or doctor

The virtuous practitioner is someone who exemplifies the virtues (excellences of character) in all roles, at all times, over a lifetime. Virtue denotes the moral worth of the individual and is a benchmark by which we measure success or capacity for human flourishing. Reflecting on the case to be discussed, the following action-guiding virtues have been identified: practical wisdom (*phronesis*), theoretical wisdom, benevolence, compassion, justice, kindness, courage, honesty, integrity, genuineness, maturity, friendship, imagination, deliberation, fidelity, veracity, diligence.

The understanding of virtue presented here is based on the Aristotelian notion of a mean – virtue lies in a mean between an excess and deficiency. Compassion is not an Aristotelian virtue but can be perceived as lying at a mean between cold indifference (deficiency) and a non-rational over-reaction to another's suffering (excess). In this article the claim that virtue ethics offers a realistic approach to the complex situations faced by nurses and other professionals will be developed and defended by means of case discussion.

Professionals need action guidance in straightforward moral decisions and also in cases where there is a clash of virtues. Professionals are guided by virtue rules.³ Where these clash, *phronesis* guides choice, for example, when compassion and honesty seem to conflict, or where truth telling can seem cruel in very particular circumstances. *Phronesis* 'is the habitual disposition to make the right choices in complex clinical circumstances' (p. 382).⁴ Although different virtues may be given priority in particular situations, *phronesis* is always there as a constant virtue, in a supporting role. We need *phronesis* for practical thinking, since it facilitates the setting of realistic ends, guides decision making, and promotes moderation on the way to achieving these ends.

Conflicting positions: compassion or duty?

In the case to be discussed, compassion and courage are two virtues that take front place in order of priority. It could be argued that compassion can also cause damage to patients because, as Blum suggests, it can be misguided and grounded in superficial understanding of the situation.⁵ *Phronesis*, however, will not let this happen. *Phronesis* acts in a co-ordinating role in the situations presented to us and the virtuous person will not, therefore, be guided by compassion in inappropriate circumstances.

The vital role of moral courage will emerge in the case to be discussed. Although compassion lies on a mean between cold detachment and emotional over-reaction, courage lies somewhere between moral weakness and foolhardiness. Moral courage is needed for advocacy, maintaining standards and, if necessary, making public interest disclosures. It is also necessary if nurses or doctors are to challenge general rules, principles and even laws that they believe to compromise their integrity. The following case illustrates how one professional (Dr Nigel Cox), governed by professional virtues (particularly those of compassion and courage), had the courage to break the rules. At the same time the nurse (Roisin Hart), who was responsible for reporting this to the authorities, was also courageous and knew that her action would attract

criticism, but she was governed by duty and would not let her compassion for the patient (virtue) cloud her judgement.

The courage displayed by Ms Hart differs from that of Dr Cox because it enables the agent to act from duty rather than compassion. My understanding of this originates from Kant's approach to virtue:

Virtue signifies a moral strength of the will ... the moral strength of a *human being's* will in fulfilling his duty, a moral *constraint* through his own lawgiving reason, insofar as this constitutes itself an authority *executing* the law (6:405)⁶ (original emphasis).

Virtue, then, is defined as moral courage.

Now the capacity and considered resolve to withstand a strong but unjust opponent is *fortitude* (*fortudo*) and, with respect to what opposes the moral disposition *within us*, **virtue** (*virtus, fortitudo moralis*) (6:380)⁶ (original emphasis).

Virtue is the strength to constrain ourselves and to consider our duty in relation to the categorical imperative and the law of our own will. Virtue is the strength to do our duty because it is our duty.

The case

In August 1991, Dr Cox, a consultant rheumatologist, injected a lethal dose of potassium chloride into Mrs Boyes. Potassium chloride is not an analgesic; it will, given intravenously, cause cardiac arrest and death within minutes. There was, it seemed, a clear and unambiguous intention to cause death and writing the prescription in the notes made it clear that there was no attempt to disguise the nature of the drug.⁷

Dr Cox had a 'warm relationship' with Mrs Boyes. She had been his patient for 13 years⁸ and it was clear that the Boyes family supported Dr Cox's action; indeed, they were grateful to him for giving the injection. Mrs Boyes was terminally ill, in excruciating pain, and had repeatedly asked Dr Cox to end her life.

Her pain was constant and grindingly severe and she made it clear to her sons and her doctors that she wished to be allowed to die and would accept no treatment other than painkillers. She had asked Dr Cox for a fatal injection which he refused. But death did not come. Two days before she died Dr Cox wrote in her notes: 'She still wants out and I don't think we can reasonably disagree.' The severe continuous pain did not respond to increasingly large doses of opioids. Dr Cox had reassured her that she would not be allowed to suffer terrible pain during her final days but was unable to honour that pledge by giving conventional drugs, including diamorphine and diazepam. As an act of compassion, he injected two ampoules of potassium chloride and recorded this in the notes. The patient died a few minutes later, peacefully in the presence of her sons.⁹

The ward sister, Hart, reported the action and the police were called.

Virtue ethics and euthanasia

The subject of euthanasia has been a focus of debate for thousands of years, and although many changes have come about historically, culturally and legally, this

issue continues to present seemingly insurmountable dilemmas in practice. Some people support an absolutist approach to voluntary active euthanasia (VAE) and will never accept that ending patients' lives intentionally is justifiable. VAE and other issues, such as termination of pregnancy, will inevitably evoke disagreement. As a profession we need to respect diversity and those who, for example, hold a strong sanctity of life view should continue to have their voices heard. Others may accept that there are circumstances where it is morally permissible to end a life intentionally, but that a change in the law would result in the potential for abuse and coercion of people who are vulnerable. These are very real and justified concerns but they do not mean that VAE is wrong in itself, or that the person who engages in this practice is a bad person.

The question asked here is not if killing a patient can ever be morally right, but rather if it is possible to kill a patient in certain clearly defined circumstances and, at the same time, behave well and flourish. We also need to consider the role of clients or patients in VAE because practitioners act in response to their requests. A focus on abstract principles can deflect from responding to individual needs, and adherence to absolutes such as 'do not kill' can leave us in a position where we are stifled and unable to be compassionate or kind. Virtue ethics does not leave us in this position because, by its nature, it looks at individuals in the context of a narrative unity and the community or family group to which they belong. The virtue approach represents a more holistic view of the person at the centre of the dilemma. In discussions of VAE there is a tendency to focus on the act of killing, but virtue ethics broadens the scope of moral appraisal since the physical act is not the only element in the situation to be considered. We must also consider the nurses and doctors operating within the current context, the relationships between patients and professionals, and the experiences, life stories and community to which they belong. The episode should not be seen as a detached event, but as part of the narrative unity of both patients and professionals. It should also be considered in the context of practice, the goals of nursing and medicine, codes of conduct, cultural and historical perspectives, and the moral calibre of practitioners.

The objectives of exploring the present case from a virtue perspective are to:

- Generate discussion and debate;
- Stimulate critical reflection in relation to accepted professional practices and attitudes;
- Defend the view that exemplary people can, in very special circumstances, step outside the code of conduct or the law in the interest of behaving well and flourishing;
- Defend the view that clients should be free to plan death in such a way that it enhances well-being and flourishing in their last weeks and days.

***Eudaimonia* (living well) and *euthanatos* (dying well)**

The case to be explored from a virtue perspective has been chosen because the details of the court case captured the attention of the public and generated much media coverage and debate. This is because a clear tension emerged between virtue (compassion and courage) and duty (codes of conduct, duties of doctors, and the law). The judge made it clear that, as far as the law was concerned, duty came before

virtue and that the professional is expected to set aside emotions such as compassion and sympathy. In this case, for the nurse, duty claimed priority over compassion and for the doctor the reverse. It is possible that in different circumstances the roles could be reversed, with the nurse breaking the rules and the doctor acting from duty. The claim that Dr Cox was motivated by compassion could be challenged. Motivation is notoriously difficult to prove, but one of the strengths of virtue ethics is that an episode or event such as that which unfolded in this case is considered in the context of the narrative unity of a complete life. We have only the court records, testimonials and media reports to use in forming an impression of this doctor's character, but these were clearly sufficient to suggest to the judge that compassion was the motivating factor.

The nature of the dying trajectory and the experience of dying represent a concern for many people, particularly those for whom it is imminent and who have become concerned more with the 'quality of death' awaiting them. There is a need to respect patients' dignity and their concerns in relation to the experience unfolding before their family. Dying well (*euthanatos*) involves living well (*eudaimonia*) until the end of life, and living well throughout the dying process depends on the responses of each unique person to the conditions in which they find themselves. Dying is 'no longer something that happens to you but something you do'.¹⁰

The judgement: duty overruled by compassion

In the court case it became clear that duty and obeying the law, rather than acting from compassion and respect for the patient's wishes, were morally overriding considerations:

The prosecution said that there was no dispute that Dr Cox was a caring and compassionate physician or that his patient had endured appalling misery during the last years of her life. He had, however, given an injection with the primary intent of killing his patient and so ending her suffering, and in doing that he had gone beyond the law ...

Told firmly to disregard Dr Cox's motives, as compared with his intent, the jury, after an eight hour wrestle with their consciences, convicted with a majority of 11 to 1 on Saturday, September 19, amid scenes of great emotional distress in court ...

Privately many of us will wish that the precise circumstances surrounding this woman's death had never come to light. One suspects that many a grateful patient has been hastened toward his or her end with the help of a caring doctor.⁹

The judge agreed that Dr Cox had acted from compassion. Mrs Boyes' pain had become worse; she was unable to absorb the diamorphine and on the day she died she was not expected to last the day. Dr Cox gave her large doses of diamorphine, but she was still crying in pain. A staff nurse said that Mrs Boyes 'howled and screamed like a dog' when anyone touched her.⁸ The judge, however, asked the jury to 'put aside any feelings of sympathy'.¹¹

In relation to Dr Cox, Mr Justice Ognall stated that:

... in doing what you did, you allowed what you knew to be your clear duty to be overruled by your deep personal distress and compassion for your patient, who was on the brink of a painful death.¹²

Breaking the law as he did seemed to make a hero rather than a villain out of this doctor, while upholding the law and exposing a crime made a villain out of the nurse. From the tone of the media coverage of the case, it is clear that the public were in sympathy with Dr Cox's motives and actions, which were generated by compassion for the patient. It is also clear that many people wished that the nurse had not reported the incident. Lord Denning (a senior civil judge), commenting on the case, said that he hoped that Dr Cox would not be struck off by the General Medical Council (GMC). He also said, 'I am sure that is what the public would want',¹¹ and Justice Ognall, in his summing up of the case, described Dr Cox as a 'distinguished professional man of unblemished reputation and character' (p. 39).⁷ A son of Mrs Boyes said he felt betrayed by the guilty verdict.⁸

Dr Cox was suspended until his case was heard by the GMC. In November 1992 he was allowed back to work and there were some conditions to be met, such as mentorship by a senior consultant and an undertaking to gain some palliative care experience 'to become familiar with a full range of techniques'.¹³ An expert witness told the GMC Committee that Dr Cox's action was an error of judgement because it went beyond legal constraints, 'But taking all circumstances into account, I think it was clearly an understandable error of judgement and I have sympathy with Dr Cox in reaching that decision.' He added that walking away would have been an option, but it would have been 'the coward's way out'.¹³

In addition to this, a witness in the court case, Dr Dixon, 'agreed that, having regard to this patient's uniquely grave condition, he knew of no other way of controlling her pain, other than by bringing her life to an end' (p. 47).⁷ Dixon added that if he were to be confronted with the same situation he hoped he would have the courage to do the same. The GMC said that intentionally shortening the patient's life was both 'unlawful and wholly outside a doctor's professional duty to a patient'.¹³ Others, not focusing on the 'duties of a doctor', assess the situation differently and see one professional courageously following a course of action that has been governed by the virtue of compassion and a commitment to the goal of medicine.

The professional dilemma: duty versus compassion

It is often said that people generally have no moral qualms about killing a terminally ill dog. However, they seem to consider it acceptable, and imperative, that human beings should linger. Stuart Horner, chairman of the British Medical Association's Medical Ethics Committee said of VAE: 'It is effectively an execution. Doctors are supposed to be relieving pain, not putting patients out of their misery.'¹⁴ To those who do not consider it to be morally wrong for doctors to 'put patients out of their misery' (if this is the wish of an autonomous adult and it is the decision of an autonomous doctor) this is a disturbing statement.¹⁵ The interesting thing about the Cox case is that compassion was considered to be a stumbling block to duty. In the virtue approach, however, and as far as Dr Cox was concerned, duty in the form of external rules, codes and laws posed as an impediment to virtue.

Ms Hart, the nurse who reported the incident, gave an account of her role in bringing the circumstances surrounding the death of Mrs Boyes to the attention of the authorities; she was clearly governed by a commitment to professional duty.¹⁶ Unfortunately for Ms Hart, Dr Cox was hailed as the hero and Ms Hart as a scapegoat.¹⁶

Ms Hart had known the patient and her family well and was clearly distressed by the suffering but she could not let this deflect her from her duty and adherence to the professional code of conduct. Dr Cox placed the nursing and medical staff in an extremely awkward position and Ms Hart had the courage to take the lead and expose what she considered to be serious misconduct and an illegal act:

By documenting what he had done, Dr Cox involved the nurses and touched so many people's lives. It was so blatant I knew we couldn't cover it up. I'd have been an accessory. The [medical] notes would go out to audit and it would come out then or leak out some other way (p. 3).¹⁶

She also said: 'It was a difficult decision, as I knew some people would disagree with me'. After the guilty verdict Ms Hart suffered threats to her safety and abuse from those who vilified her. She had acted in good faith and obeyed the rules, but the rules conflicted with many people's views of behaving well in these particular circumstances. Despite having the moral courage to do as expected by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) she felt let down by their response.

I am disappointed the UKCC didn't come out early on with some sort of statement supporting me. They could have used it as a chance to reinforce the code of conduct (p. 4).¹⁶

Yet such was the strength of her conviction that she would not be put off acting from duty again:

I also have to say that, despite everything, I would do it over again if I had to. I just want the system changed so that other nurses faced with a similar dilemma can make the right decision without having to put up with the sort of persecution my family and I have been through (p. 4).¹⁶

Different voices

It is my contention that the problem here is not that we have one good and one bad person. Both the nurse and the doctor were good people and caring professionals, but they were listening to 'different voices'. From early in professional life, empathy and compassion are nurtured, but we expect nurses and other professionals to set aside compassion in the interests of obeying abstract general rules. The doctor, however, was governed by virtues; compassion was therefore action-guiding in this case. The nurse, on the other hand, was governed by rules; thus adherence to a code was her action-guiding consideration. The doctor was guilty in law but good in the eyes of many; the nurse was above reproach legally and professionally but was, nevertheless, vilified and subject to abuse.

Voluntary active euthanasia and flourishing

One of the reasons often given for refraining from carrying out requests for VAE is that killing patients runs contrary to the goals of nurses and doctors. Even doctors

who believe that VAE can be carried out, for example, by a patient's partner, think that doctors should not be involved. However, others think that VAE does not go against the goals of nursing or medicine and consider it to be in a patient's overall best interest. In virtue terms, it can be argued that VAE facilitates *eudaimonia* (living well, flourishing) because dying is a life event, and not dying well frustrates the goal of flourishing and well-being for both client and professional.

Virtue ethics does not consider discrete episodes in life, but looks at a person at a certain point on a journey; this applies to the agent (doctor or nurse) and the patient. Any 'end-of-life' choice, therefore, is made within the context of patients' history, and the way they expressed themselves in life; dying is part of that narrative, not a 'full stop' at the end of the story. People depend on others to help them to realize their goals and the central moral question of caregivers is, therefore: How can I enable the patient to live a good life and die a good death?¹⁷ Decisions such as when physicians should cease efforts to prolong life and when they can hasten death (if ever) have to be made in the context of the complete narrative of the individual patient's life. From a virtue perspective the role of imagination is also vital in end-of-life decisions because we have to imagine the experience from the person's perspective, from within the narrative of the other's life, rather than from within our own experiences.

Dworkin suggested that:

making someone die in a way that others approve, but he believes to be a horrifying contradiction of his life, is a devastating, odious form of tyranny (p. 217).¹⁸

The word 'tyranny' has been used by Toulmin in his critique of general principles and rules.¹⁹ This 'tyranny of principles' generates scenarios such as that raised by Dworkin, and from the professional's perspective, the tyranny of principles, rules and doctrines can force them into a position where they feel obliged to walk away from compassionate acts. There are various conceptions of a good life and a physician must have respect for the patient's values, life plans, and beliefs.

Consider here how forcibly depriving someone of the sort of death they had authentically requested and envisaged is something regarded as a terrible violation or rupture of wholeness (p. 83).¹⁷

The virtuous response (action-guiding virtues italicized)

Both patient and practitioner have a responsibility when it comes to flourishing or living (and dying) well. Dr Cox and others who have responded to patients' requests in this way cannot have a cavalier attitude to the regulative ideals espoused by the community and the profession, but they can use judgement in consideration of rules and precepts, and this requires *phronesis*. Professionals must balance their own *integrity* with professional concerns and patients' interests. In doing this they perceive what is good and recognize the appropriate response.²⁰ Competent patients must also deliberate and be guided by *phronesis* in making a choice and making a request. Virtue ethics highlights the interdependence of people; helping another will lead to human flourishing generally, and both parties to the agreement must be considered in any subsequent moral appraisal.

McDowell makes an interesting distinction between virtue from the 'inside out' and virtue from the 'outside in'.²⁰ In this case compassion that emanates from within the agent represents virtue from the 'inside out'. Obeying rules, or adhering to a code that is external to the agent represents virtue from the 'outside in'. From a strong virtue perspective the individual must be motivated from virtues such as those listed earlier, which come from within. Dr Cox did not take the 'cowardly' route by walking away. He took the *courageous* step and put the patient first. He could have taken an objective and impartial approach, as traditional approaches and professional codes demand, and put aside the *friendship* that had been established over the years. He could have expressed regret at not being able to relieve pain by conventional means, thus justifying his inability to remain *faithful* to the promise of a pain-free death that he had made. Within the profession this would have been acceptable, but he would have felt that he had failed the patient, and had been unkind and callous in his decision to refrain from carrying out her request. He was, in his transparency (not attempting to mislead or cover up his act), *honest* and *truthful* and clearly not looking for a way out such as might be found in an appeal to the principle of double effect. Any failure to exemplify these virtues would damage his *integrity* and his capacity to flourish, which was inextricably linked to the flourishing of Mrs Boyes. The judgement involved in coming to a decision to act was guided by *phronesis*. On the other hand, the nurse also exemplified virtues, but from a weak virtue perspective, with virtue complementing duty and duty being prior and action-guiding. She was compassionate and kind and showed moral courage, but adherence to duty, rules and principles was the focus of this courage.

Discussion

Dr Cox's act was the response for which Mrs Boyes and her family had hoped. In a situation like this I believe that an agreement to carry out euthanasia can facilitate human flourishing because euthanasia and *eudaimonia* are clearly woven together. In doing what he did, Dr Cox courted possible ruin, but he made what he considered to be an appropriate response in the circumstances. External goods such as money and a good reputation can be achieved without the virtues. Gaining internal goods (those that sustain a practice), however, requires some consideration of the authority of practice standards and the virtues of justice, courage and honesty.²¹ I am convinced that the Cox case exemplifies all of these. Dr Cox was not struck off by the GMC; he was given a reprimand and allowed to return to work.

This could be challenged by the claim that Dr Cox's behaviour did not conform to others in his community; after all, he was 'out of step' with his colleagues in both nursing and medicine, and Ms Hart, for example, suffered considerable stress and hardship for doing her duty and reporting the incident.¹⁶ He did break the law and he used a non-therapeutic drug, thus making his intention clear. There was also some suggestion that he was lacking in some element of virtue (theoretical wisdom) and that he needed some training in palliative techniques. Other doctors, however, do the same thing (act) and avoid prosecution by using analgesia and appealing to the principle of double effect. Many doctors genuinely end lives as a side effect of pain relief, but there is a possibility that others do so with an intention to end life for compassionate reasons, but without the courage and honesty that accompanied

compassion in the Cox case. If we were to consider the situation within a virtue approach, there would be no need for the principle of double effect because, for some, it is no more than a psychological manoeuvre used to justify the otherwise absolute prohibition on killing innocent people²² and avoid the consequences that unfolded in these circumstances.

Conclusion: guilty but good

The judge in the Cox case said that no allowance can be made for a consideration of virtues such as compassion and his response reflects Rosenberg's suggestion that we should not allow ourselves to be blinded by humane and sympathetic impulses.²³ I believe that this expectation is unrealistic, and that it creates a tension within the practitioner as a moral agent. Nurses and doctors are encouraged to develop empathy and compassion, but to lay them aside when they conflict with the law or a code of conduct. This 'pushes a square peg into a round hole' and encourages the feeling that good doctors and nurses are those who can walk away from situations calling for a compassionate response. Expecting a person to acknowledge their sensitive responses and then 'bracket them out' is asking someone to sacrifice his or her integrity. In relation to moral integrity, Dr Cox had no morally acceptable alternative to ending Mrs Boyes' life. To let her continue with futile suffering in the interests of adhering to a rule (do not kill) would not be in keeping with flourishing for patient or doctor. It took courage, but the alternative was probably unthinkable for the people in this situation.

A virtue approach takes account of the compassionate response and acknowledges it as action-guiding, providing the circumstances are appropriate. As Hare says, if a person feels empathy and compassion, 'benevolent action must proceed' from these feelings²⁴ and, even though Hare writes within the framework of traditional moral theory, in this instance from a Christian perspective, it is interesting that he uses the word 'must' – benevolent action is presented as an imperative. This concurs with the virtue perspective. When faced with a decision the virtuous person is guided by a disposition to be benevolent in the interests of human flourishing; there is no alternative for the virtuous agent. This possibly explains the difficulty encountered by the jury in the Cox case, and the emotional response in the courtroom after the guilty verdict. It is also noted by van Zyl that, despite the fact that 'mercy killers' are usually found guilty of murder, they are generally given light sentences because of extenuating circumstances.¹⁷

On the other hand, governed by duty, Ms Hart took another path and considered it to be the only option open to her. She had no choice if she wanted to avoid breaking the rules.

In the trial of Dr Cox a witness said: 'Five minutes of peace is not very much but it was all Dr Cox could give, and he gave it (p. 48).'¹⁷

Despite the 'guilty' verdict, Dr Cox, having made a judgement based on action-guidance of the virtues, was considered by many to have behaved well. The GMC said that intentionally shortening the patient's life was both 'unlawful and wholly outside a doctor's professional duty to a patient.'¹³ Dr Cox went beyond the duty normally expected in a doctor-patient relationship and was prepared to break the rules for Mrs Boyes. In the court case this was considered to be a fault, overstepping the mark, but there is the possibility of another interpretation of this. I anticipate some challenge to

the following suggestion: to claim that virtue ethics can accommodate the acceptance of euthanasia as behaving well, as exemplifying the virtues, and as a contribution to human flourishing, is open to criticism, but to claim that it is supererogatory is moving into more controversial territory. I am suggesting that, in the case discussed, as with other similar cases, a virtue ethicist could claim that VAE, in certain circumstances, is not just morally acceptable, but praiseworthy, and therefore supererogatory. Supererogatory acts are 'acts which go beyond what is obligatory by ordinary moral standards'²⁵ Doctors, nurses and relatives who help people to die in circumstances such as those discussed challenge the law, codes and norms. Cases like this encourage professions to reflect and perhaps to question and challenge conventional professional notions of 'morally acceptable' and 'morally praiseworthy'.

A supererogatory act involves sacrifices not normally incurred in the course of duty (professional practice). In the course of duty Dr Cox could have written prescriptions for more analgesia and walked away. In this way he would have continued in his career without the detrimental effects of the legal and professional battles that judgement and subsequent action generated. People will, according to their appraisal of Dr Cox, consider him to be a maverick or a pioneer, a saint (or a 'Good Samaritan'), a hero, a villain or a practitioner guilty of misconduct. It is clear from the transcripts of the trial that he was a well liked and respected professional. Not everyone can display such heroic qualities, which perhaps explains why few people are prepared to take this sort of action.

A virtue ethics approach to a situation such as this forces us to look at the serious question of why we accept a legal system that punishes the good person, while apparent callousness induced by the duty to refrain from absolute prohibitions is accepted as 'doing the right thing'. Both professionals involved in this case suffered as a consequence of their actions. Nurses and doctors need to have the freedom to respond compassionately in situations such as this. The law conflicts with the possibility of a compassionate response and creates tensions between professionals, clients and their families. I am not suggesting that professionals should break the law, but, when the law frustrates their ability to take compassionate action, then the law needs to be challenged more vigorously by nurses, doctors and all those who care. At the same time we cannot ignore the fact that there are people within the professions who consider the deliberate killing of one person by another to be prohibited in all circumstances and they will not be convinced by these or any other arguments. There is also the possibility that some will act from vice, not virtue, and those who are vulnerable in society need to be protected from these individuals.

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