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# A DIALOGUE BETWEEN VIRTUE ETHICS AND CARE ETHICS

ABSTRACT. A dialogue between virtue and care ethics is formed as a step towards meeting Pellegrino's challenge to create a more comprehensive moral philosophy. It is also a dialogue between nursing and medicine since each practice draws on the Greek Virtue Tradition and the Judeo-Christian Tradition of care differently. In the Greek Virtue Tradition, the point of scrutiny lies in the inner character of the actor, whereas in the Judeo-Christian Tradition the focus is relational, i.e. how virtues are lived out in specific relationships, particularly unequal relationships where vulnerability of one of the members is an issue. In a care ethic relational qualities such as attunement rather than inner qualities are the point of scrutiny. A dialogue between these two traditions makes it possible to consider the relational virtues and skills of openness and responsiveness that are required for a respectful meeting of the other.

KEY WORDS: virtue ethics, care ethics, relational ethics, moral philosophy

## 1. INTRODUCTION

The virtue tradition as presented in medicine by Pellegrino and Thomasma[1] offers a needed corrective for engineering and market models of health care delivery that erode the patient-practitioner relationship. Ironically, engineering and market models of health care owe their success, in part, to the failure of health care practitioners to practice virtue ethics in controlling health care costs and equitably allocating resources. Thus, proponents of a virtue ethics are confronted with cynicism and skepticism about past excesses in health care costs and current policy discourses dominated by economism and scientism.[2,3,4,5] The restoration of virtue ethics is also difficult because of an eclipse of the legitimacy of practice-based clinical knowledge. This paper is a response to Pellegrino's recent assertion:

> ... that virtue likely can be restored as a normative concept in the ethics of the health professions and ... that even in this limited realm, virtue cannot stand alone but must be related to other ethical theories in a more comprehensive moral philosophy than currently exists[6]

The goal of this essay is to create a dialogue between virtue and care ethics as a step towards meeting Pellegrino's challenge to create a more

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comprehensive moral philosophy. In some respects this could be considered a dialogue between nursing and medicine since each practice draws on the Greek Virtue Tradition and the Judeo-Christian Tradition of care in different ways. A major point of contrast between the virtue and care ethics lies in the *way* virtues are taken up in the two traditions. In the Greek Virtue Tradition the point of scrutiny lies in the inner character of the actor, whereas in the Judeo-Christian Tradition, the focus is relational, i.e. how virtues are lived out in specific relationships, particularly unequal relationships where members are vulnerable.

## 2. VIRTUE AND CARE ETHICS

In studies of excellent nursing practice, my colleagues and I have found relational and skillful attunement characterized by the virtues of openness and responsiveness.[7,8,9,10] A care ethic is relational and focuses on meeting the other with respect characterized by recognition, support for growth or self-acceptance, and/or allowing the other "to be."[11,12]

Pellegrino describes the idea of virtue for medical education as:

> (1) excellence in traits of character, (2) a trait oriented to ends and purposes (that is to say, teleologically), (3) an excellence of reason not emotion, (4) centered on a practical judgment [phronesis], and (5) learned by practice.[13]

Pellegrino's points 2, 4 and 5 hold much in common with care ethics, while distinctive contrasts can be made between points 1 and 3. Regarding Point 1, on character traits, a care ethic shifts the focus from inner character to relational qualities such as attunement. The point of scrutiny is on the actual concerns in the relationship since focusing on "inner character" can create a self-involvement that prevents the person from meeting the other. Even so, the relational virtues and skills of openness and responsiveness are required for a respectful meeting of the other.

Regarding point 3, in contrast to an emphasis on reason not emotion in the Virtue Tradition, a care ethic explores the relationships between emotion and rationality. A care ethic incorporates emotion and rationality and emphasizes particularity and relationship. A care ethic creates a broader vision of emotion than "emotivism" or a disruption of reason implied in the traditional separation of passions and reason in the virtue tradition. An Aristotelian vision of emotion governed by reason is a step in the right direction, because it comes closer to capturing the way that one's emotional responses are developed in the acquiring of a practice or a habitus.[14]

A care ethic offers a corrective to ethnocentrism commonly experienced in a normative virtue ethics where shared norms create false expectations

that prevent meeting the other in his or her own terms. Openness and responsiveness to the other require that the goods of all parties be explored before presuming what notions of good are at stake. Focusing on norms may not be the only source of ethnocentrism. Focus on one's own inner character, when primary, also blocks meeting the other in his or her own terms. The health care provider-patient relationship is for the sake of the patient's growth and well-being, not for the self-improvement of the practitioner's inner character or even of society as the Danish theologian, Logstrup, points out:

> Mercy consists of an urge to free another human being from his sufferings. If it serves another goal, for example, the stabilization of society, it is replaced by and indifference towards the other person's sufferings. The ulterior motive transforms mercy into its opposite.[15]

Cynicism and disillusionment over power and profit motives might tempt us to settle for benign benevolence for the sake of improving society. But displacing one's primary concerns for the other, by self development or improving the society, does not ensure benevolence in the larger society and diminishes a coherent understanding of health care practice for practitioner and patient alike.

Care ethics and Aristotelian phronesis [practical judgment] share a vision for responding to the particular:

> Responding to the general situation occurs when one follows ethical maxims and gives the standard acceptable response . . . When an individual becomes a master of his culture's practices or a professional practice within it, he or she no longer tries to do what *one* normally does, but rather responds out of a fund of experience in the culture and in the specialized practice. This requires having enough experience to give up following the rules and maxims dictating what *anyone* should do, and, instead, acting upon the intuition that results from a life in which talent and sensibility have allowed learning from the experience of satisfaction and regret in similar situations. Authentic caring in this sense is common to *Paulian* agape and Aristotelian *phronesis*.[16]

Recovering the primacy of the good over the right in many particular instances, as recommended by Pellegrino and Thomasma,[17] requires a common understanding of what it is to have a practice. Here the virtue tradition and care ethic meet since both are lodged in social practices and communities. The rest of the paper is devoted to laying out the nature of socially organized practices common to virtue and care ethics: (l) Practice that uses science and technology is contrasted to science and technology as ends. (2) Then scientific reasoning and its assumptions are contrasted with clinical reasoning in transitions.[18,19] (3) The practical and theoretical links between clinical and ethical reasoning are examined. (4) Finally, the dialogue between the virtue tradition and the care ethic will be

extended by articulating aspects of a care ethic evident in nurses' comfort practices.

These four points of dialogue between virtue and care ethics build a case for reviving our understanding of health care as *a caring practice carried out by practitioners of trustworthy character*. This focus on virtue and care ethics is not intended to replace rights-based principle ethics. Health care also requires respectful treatment of rights for creating equity and caring for strangers. Adjudicating rights will continue to be necessary in cases of extreme breakdown, but so will insights from both the virtue and care traditions. We have much to gain by responding to Pellegrino's challenge to create a dialogue between current theories of ethics.

## 3. DISTINCTIONS BETWEEN PRACTICE AND PRODUCTION

For Aristotle, virtue was closest to skills for acting in specific situations and relationships. Such skills were not mere isolated techniques relevant to the production of things, but rather were located in a practice that required *phronesis* and actions of good practitioners. Practice and the *telos* inherent in its craft influence character. Character cannot be reduced to will, or beliefs, or "inner" intents as Aristotle[20] notes:

> . . . for building well makes good builders, building badly, bad ones. If it were not so, no teacher would be needed, but everyone would be born a good or bad craftsman.
>
> It is the same, then, with the virtues. For actions in dealings with [other] human beings make some people just, some unjust; actions in terrifying situations and the acquired habit of fear or confidence make some brave and others cowardly. The same is true of situations involving appetites and anger; for one or another sort of conduct in these situations makes some people temperate and gentle, others intemperate and irascible (1103b; 10–20). But let us take it as agreed in advance that every account of the actions we must do has to be stated in outline, not exactly . . . the type of accounts we demand should reflect the subject-matter; and questions about actions and expediency, like questions about health, have no fixed (and invariable) answers. And when our general account is so inexact, the account of particular cases is all the more inexact . . . and the agents themselves must consider in each case what the opportune action is, as doctors and navigators do (ll04a; 36–1104a; 5–9).

MacIntyre[21] defines practice as a coherent, socially organized activity with notions of good practice within the practitioners' understanding and skillful comportment. A practice has shared understandings about goals, skills and equipment and is continually being worked out in new contexts. Practitioners can recognize strong instances of excellent or poor practice. Techniques or tasks completed without engaging in a caring relationships with particular patients with particular sets of needs and concerns do not constitute a practice.[22] A health care practitioner uses science and

technology but that use must be based upon worthy ends as understood and agreed upon by patients and practitioners.

Bureaucratized market models achieve their efficiency by separating means and ends and substituting means for ends. This approach overlooks the craft, judgment, and relationship required for health care. It assumes that attentiveness and excellent comportment require no more than commercial relationships based upon simple exchanges. But caring for vulnerable and ill persons requires more than a profit motive. Compassion and caring practices are required. I will present a case for the centrality of these moral arts for clinical and ethical comportment and reasoning in nursing.

In order to focus on the craft and relational side of the practitioner/ patient relationship, the terms comportment *and* reasoning are used. The patient-practitioner relationship cannot be reduced to reasoning alone, or to that further reduction of "clinical decision making," since reasoning occurs primarily in diagnostic and quandary situations, while focusing on decision making alone overlooks action and relational aspects of situations. It is both a practical and logical error to examine breakdown situations and assume that the analysis depicts the same processes that occur in excellent practice.[23] When the clinical situation is straightforward and relationships are unconflicted, the patient-practitioner relationship is best depicted by excellent comportment, rather than by reasoning or the decision-making processes. An ethic of virtue necessarily focuses on everyday skillful comportment where one encounters "the continuities, the habits of behavior which make us the persons we are."[24]

## 4. DISTINCTIONS BETWEEN SCIENTIFIC AND CLINICAL REASONING

Increasingly, legitimization for medical and nursing knowledge comes from science and technology. This is preferable to guiding practice by bogus claims based on unwarranted knowledge and powers. But clinical knowledge that incorporates the best science and technology has its own legitimacy claims. When legitimization claims are lodged only with science, scientific and clinical reasoning are conflated and the craft, judgment, relationships and moral virtues required by clinicians are overlooked.

Taylor[25] contrasts reasoning in transition with the formal characteristics of rational justification used in scientific reasoning, that is analogous to static or "snapshot" reasoning. Scientific reasoning rests on spelling out all the relevant criteria and the essential characteristics of the situation. Clinical and ethical reasoning in transitions is more like a "moving

picture" because gains and losses in understanding are considered along with a range of possible futures. But reasoning and decisional issues alone cannot account for or create good clinical practice. The good practitioner must be attuned to the clinical situation and be skillful in intervening in ways that are true to the patient's interests and condition. Such everyday skilled comportment requires good science and its skillful use for clinical practice. Yet good science, though necessary, is not sufficient for creating good practice. The clinician must recognize when a scientific finding might be relevant in a particular case. Good practice requires trustworthy, skilled practitioners. Finally, the practitioner must develop the moral art of attentiveness, and willingness to be with patients who are suffering. This cannot be effected on the basis of mere exchange or natural affinities, because suffering and difference require courage, caring and openness in the face of the clinician's and patient's own sense of finitude and vulnerability.

Patients do not present themselves with singularly clear diagnostic categories, nor do clinical conditions remain stable. Therefore, clinicians must follow the course of the illness as it unfolds. Even clinical trials and large outcome studies must be interpreted in light of the particular patient's condition. The formal criterial reasoning of science yields static assessments and absolute judgments. For example, the clinician interprets laboratory results according to both normative expectations and the patient's own trends. Therefore, the excellent clinician always engages in reasoning in transitions, making use of gains and losses in understanding as the patient's condition changes:

> Practical reasoning . . . is a reasoning in transitions. It aims to establish, not that some position is correct absolutely, but rather that some position is superior to some other. It is concerned, covertly or openly, implicitly or explicitly, with comparative propositions. We show one of these comparative claims to be well founded when we can show that the move from A to B constitutes a gain epistemically. This is something we do when we show, for instance, that we get from A to B by identifying and resolving a contradiction in A or a confusion which A screened out, or something of the sort. The argument fixes on the nature of the transition from A to B. The nerve of the rational proof consists in showing this transition is an error-reducing one. The argument turns on rival interpretations of possible transitions from A to B, or to A. The form of the argument has its source in biographical narrative. We are convinced that a certain view is superior because we have lived a transition which we understand as error-reducing and hence as epistemic gain.[26]

When scientific reasoning (rational justification) is generalized or read into situations where reasoning in transition is required, scientism is substituted for science.

Rubin[27] analyzed the interviews and observations of a group of experienced, but not expert, nurses and found that they did not experience themselves as making clinical and ethical judgments. They considered

themselves as collectors and adjudicators of objective clinical data related to cause and effect, a confusion created by conflating scientific reasoning with clinical judgement. These nurses did not experience their own moral agency in making qualitative distinctions or in taking responsibility for their choices and actions. Valuing scientific reasoning while ignoring clinical reasoning in nursing school made it difficult for these clinicians to observe clinical and ethical reasoning and experience their own moral agency as clinicians.

## 5. BECOMING A GOOD PRACTITIONER, THE LINKS BETWEEN CLINICAL AND ETHICAL COMPORTMENT AND REASONING

I will now summarize our study of clinical expertise and skill acquisition among 130 critical care nurses in eight different hospitals to relate the links between clinical and ethical reasoning.[28] This study examined skill acquisition from beginning to the expert levels of nursing practice. We found that the emotional responses to clinical situations of competent level practitioners depended on their own and others' appraisal of their practice. Competent nurses had a sense of whether or not they understood what was going on in the clinical situation. Their sense of whether or not they had a good grasp of the situation guided their problem search. They recognized that their perspectives on the clinical situation guided their actions, and they could more readily see multiple ways of understanding the same situation. Therefore they consciously deliberated on which perspective should guide their practice. This combination of newly gained competency, and understanding of risk and responsibility for choosing a perspective created emotional responses to their practice outcomes. If things went well for the patient, they felt good; however, if they made a mistake or things went poorly, they felt regret.[29] Using an analogy from everyday skillful comportment, those learning to drive a car will not become good, safe drivers if they delight in turning corners on the edge of their tires. Instead they should experience danger and risk.

The nurse's skills of involvement with the situation and interpersonally with patients and families were crucial to developing expertise. Indeed emotional engagement allows one's body to gear into the situation.[30] Nurses who did not experientially learn skills of involvement that allowed attentiveness but not over-involvement did not go on to become expert nurses.[31]

Another related way that emotion serves to guide problem identification and rationality lies in the experientially-learned sense of salience that is characteristic of proficient and expert practitioners. For one who

understands a clinical situation, some things just stand out as more or less important (salient).[32] Practitioners develop a practice-based way of seeing situations and being in clinical situations. This does not imply that a clinician's sense of salience is infallible; indeed, excellent practice requires that the practitioner stay open to changing relevance in clinical situations. But a practitioner would be unable to act at all if every aspect of the situation seemed equally important. Good clinical practice is linked to an ethical sense of desirable outcomes, and responsiveness to patient concerns and interests. Here virtue tradition and care ethics augment one another.

Everyday clinical and ethical comportment and reasoning are guided, not so much by quandaries and extreme cases that stretch the usual boundaries of good practice, but by usual understandings about what are worthy, competing goods in particular clinical encounters. These are essentially encounters where openness and responsiveness to the other shape the encounter. For example, the clinician must make qualitative distinctions between comfort and suffering.[33] These qualitative distinctions cannot be made through objectification, or rational calculation, they require discernment in the particular relationship and situation. Nurses must also develop a sense of their agency in responding in ways that alleviate suffering, overcome confusion and conflict and/or allow the other to be.[34] This view of "emotional response" contains within it a vision of habits of skills, thought and relationship. Emotions are more than "noises" that trouble our cognitive processing; they create the possibility of rational action. Emotional responses can act as a moral compass in responding to the other person. Emotions, viewed in this way, signal a response to the plight of the other and guide perception of salient moral issues, and thus are not empty of cognitive or moral content or necessarily disruptive of reasoning processes.

The expert can identify or find problems because of perspectives from past clinical situations. Consequently, expert clinicians do not just engage in knowledge utilization; they develop clinical knowledge. A practice in this view is not a mere carrying out of an interiorized theory; it is a dynamic dialogue in which theories and new understandings may be created. The expert is called to think in novel, puzzling or breakdown situations.

## 6. ARTICULATING CARING PRACTICES IN CLINICAL NURSING

I have argued above that, in order to see the relevance of virtue and care ethics for health care practitioners, we must first recover an understanding of the nature of clinical and ethical comportment and reasoning lodged in

a practice. Virtue and care ethics can be articulated from studies of actual practice. The rest of this paper is devoted to illustrating nurse's moral comforting practices drawn from a study of critical care nurses.[35]

Central to nursing practice are many "comfort measures": physical touch, holding the hand, being visible, wiping tears, providing a warm blanket, making soothing talk, providing for the bodily comforts with smooth, dry bedding, movement, light, warmth, color, distraction and the familiar. Comforting is occasioned by distress, loss or suffering, and is dependent on timing, trust, the relationship, and the person's openess to comfort. To comfort means to sooth and console as well as to strengthen, aid and encourage. Sometimes suffering is inconsolable and comfort measures may feel like an affront to a collapsing world that will not sustain comfort. Our everyday understanding of the word "comfort" acknowledges an inter-related mind-body-person-world. Comfort in one sphere influences all the others.

Nurses often use the phrase "comfort measures" to describe a myriad of comforting practices. "Comfort measures" is a naturally occurring phrase that is pervasive in the 130 interviews. Nurses were not asked specific questions about comfort measures unless they used the phrase, then probes that elicited more concrete descriptions of actions were used. One is hesitant to promise to comfort or be comforted because comfort is never fully born of choice and freedom. Because it can mean so many things to different people in different situations, this broad term and ambiguous practice does not easily find its way into technical and scientific discourse. Nurses almost never claim to have "comforted" someone, since how the person responds or appropriates the comfort measures determines their effect. Comfort measures are most often distinguished by nurses as a way of "being with" patients.

It is impossible to formalize all forms of comforting. This limit to formalizing comfort in terms of isolating elements and establishing principles may explain why nursing literature and public discourse are so silent on comforting practices. Also comfort measures can appear trivial, homey, ordinary, and somehow less legitimate and less important when compared to powerful technological interventions that "fix" or "cure." To comfort, one must acknowledge loss or suffering and admit the limits of protection and immunity. Comfort calls for solidarity and connection rather than distance and control.

Since comfort measures are what one does in the midst of discomfort, distress or suffering, offering comfort measures requires the perception that comforting is needed, a recognition practice-dependent upon attentiveness,

noticing and presencing as illustrated in the following nurse's description of "listening" to an infant:

> There is something about listening to the patient. This particular patient I'm thinking of wasn't speaking, but was getting his message to me – you know, as if the baby is saying: "I'm not doing much of anything, so everyone better leave me alone." So, once people started leaving him alone, his own systems, for whatever reason, started to function again . . . It's like when the baby seems to be saying, "No, we're not going to do it that way – I can only eat so much, or I can only tolerate so much." So we try to find out what the baby seems to want to do – I know that sounds strange – but letting the baby guide his care a little bit more directly rather than putting him into the mold we think he should be in. This holds true for feedings and oxygen . . . This one infant started to come around once we put him on his tummy and started feeding him.

Without attunement to bodily rituals and demands one cannot comfort or be comforted. Comfort is central to healing practices, because comfort and reassurance (the opposite of fear, distress, anxiety) offer the person space to regroup, to allow the body to recover, heal and grow. The nurse above goes on to say:

> Ordinarily, we don't feed babies when they're on ventilators, but this baby had tolerated everything else, was getting old, and needed to start feeding. So, we started feeding him and we found that he responded very well to the feedings – and that he wanted to stay on the ventilator – so we accommodated him. And he began to get better, and within two weeks, we were actually able to get him off the ventilator and put him on a nasal cannula.

In addition to the perception that comfort is needed, one must understand the situation and be able to imagine what would be experienced as comforting. The nurse must experientially learn what is (in this situation) comforting touch, what talk is soothing, what sources of support work for particular patients and families – what is a comfortable closeness or distance, what demeanor and gestures convey understanding and responsiveness? Because these skills are experientially learned within particular relationships, they never can be adequately formalized or turned into techniques or procedures. They exist in relationship. Attunement to both the other's needs and responses to the comforting offered are crucial to skillful comforting.

Comfort measures, as nurses talk about them, are integral to setting limits on technology use, though there is always a tension between the search for a technological fix that may bring comfort and the need to comfort in the face of the limits and discomforts of technology. Comfort measures are seen by some nurses as a first response before medical interventions so that sedation and paralysis are not used as substitutes for everyday comfort measures. Nurses talk about the dangers of substituting drugs for human solace and physical comfort while addressing the need

to provide sufficient pain medications so that patients do not needlessly suffer.

The capacity to be comforted (consoled, soothed) is a socially developed capacity that neonatal and pediatric critical care nurses seek to foster and protect. The challenge is to develop the infant's ability to be comforted by human connection in the midst of highly technical environments. It is technically feasible to offer sedation and pain medication in lieu of human comfort measures at the expense of ushering an infant into a human world where one must learn to do self-comfort as well as be comforted by touch, motion, and holding. An infant that has not learned to find sufficient comfort in the human world is indeed handicapped. Balancing technology and touch calls for astute attentiveness and judgment since it is equally dangerous to cause needless suffering due to insufficient pain medication and sedation.

Pain and suffering shatters the familiar world, so that adults must learn how to comfort themselves and be comforted with an unfamiliar body in unfamiliar situations. The challenge in caring for adults is to co-discover what is comforting, since one's comfort is dependent on past socially-learned embodied responses and these must be called upon in a new context. For the adult who prefers control and fears dependency and helplessness, comfort measures may entail creating small spheres of possible control to stem the tide of fear, dependency and helplessness. But all human dependency and helplessness cannot be masked. And to be able to receive comfort in the midst of dependency can help one confront and accept inescapable dependencies with solace and perhaps even grace.

The ethical claim is that self-nurturance and human dependency on others for help and comfort are more basic and sustainable than technological dependency. Comfort measures defend against unnecessary discomfort. Nurses offer comfort measures in the midst of doing painful procedures, therefore inflicting pain as a result of therapies is a major moral and coping challenge to the nurse whose aims are to comfort and limit suffering.

Comfort is associated with the Nightingale imperative to put the body in the best condition for self-repair and healing. The following seven major kinds of comfort care are pervasive in the nursing narratives: (1) Care of the body as a source of comfort; (2) being physically comforting through touch and putting patient/family members at ease; (3) providing rest and limiting disruption; (4) taming the technical environment; (5) being available without being intrusive; (6) facing ethical tensions between pain relief, sedation paralysis and comfort measures; (7) the dilemmas and ethical challenge of inflicting pain with therapies; (8) comforting through

familiar rituals and routine; (9) comfort care offered to the dying and their loved ones.

Birth, illness, injury, loss, recovery, suffering, dying are human events whose meanings and practices exceed technical reductions of medical disorders to be fixed or cured. Even if comfort measures such as rituals, religious practices, and routines did not have their well-earned scientific medical legitimacy of providing a sense of well-being and calming the stress response (they do have this scientific rationale based upon empirical research), they would still have human legitimacy related to human goods – a life worth living and the very acts of creating culture, human connections and traditions.

In nursing and medicine we live out the tensions of objectifying the body, treating it as a collection of physical structures and mechanical functions, so that we can overcome the aversion and human taboos of inflicting pain, doing surgery and distancing blame and shame from the vulnerabilities associated with embodiment. The objectification of science is necessary for the therapies of medicine, but therapies are absolutely dependent on larger human goods such as decreasing suffering, preserving human concerns, promoting recovery, and prolonging the quality of life. Objectification and distancing are useful for coping with the terrors of inflicting pain and facing the risk of death, but they are only useful for circumscribed periods and always run the risk of usurping human concerns. Comfort measures can appear ordinary and relatively ineffective when compared to repairing, let us say, heart defects surgically, yet these heroic procedures are complementarily dependent on comfort measures, and cannot be sustained without them.[36] The challenge is to create organizational cultures that can accommodate both the science and the human goods associated with confronting the human realities of risk, suffering, loss and death, and sustaining whatever comfort measures can be offered.[37]

## 7. SUMMARY AND CONCLUSIONS

Health care does not act like a commodity, in that the people most needing health care services are often least able to pay, or even request those services. The ethos of the buyer-seller relationship does not adequately capture the moral demands of caring for the disenfranchised, the vulnerable, and the suffering. We imagine in good Western fashion that we can develop formal outcome criteria for medical care decisions based upon large population statistics, and thus eliminate the skill and judgment involved in moving from the general to the particular. We assume that formal criterial reasoning exemplified by the development of cost/benefit

ratios and algorithms can replace clinical judgment or reasoning in transition. Instead we need to study the ways the clinician takes up the general statistical and algorithmic data in reasoning in particular cases, where the situation is under-determined, open and unfolding.

I agree with Pellegrino[38] and his colleagues that medicine and nursing are good candidates for the restoration of virtue ethics, because notions of the good are essential to clinical and ethical comportment and reasoning, and because it is impossible to separate clinical and ethical reasoning in a practice. When my colleagues and I study the practice of nurses, we find that they are working out their notions of good practice in their daily encounters with patients. When they fail to perceive clinical and ethical judgments they mistakenly assume that they are merely engaged in rational justification about cause and effects. We need to recover the distinctions between clinical and scientific reasoning in nursing and medical education and legitimize the comportment and reasoning processes that characterize clinical practice. Finally we need to articulate and attend to the moral art of attentiveness and caring relationships that protect patients in their vulnerability while fostering growth and limiting vulnerability. This calls for bringing caring practices in from the margins of our thinking about practice and combining care and virtue ethics.

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