Virtue, Duty, and the Moral Ecology of Organ Donation: From Kantian to Neo-Aristotelian Perspectives in Dialogue with Orthodox Theology

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Abstract: This article extends a recent Kantian-inspired dialogical framework for addressing spiritual and moral obstacles to organ donation by bringing it into conversation with neo-Aristotelian virtue ethics. Kantian ethics secures non-negotiable constraints such as respect for persons, dignity, and consent, but it is less well equipped to explain how trust, moral motivation, and institutional credibility are formed and sustained in practice. Drawing on contemporary bioethics, nursing ethics, and neo-Aristotelian analyses of organ donation, we argue that concepts such as character, practical wisdom (*phronēsis*), and moral formation provide an essential complement to duty-based reasoning. This synthesis helps explain why organ donation may be morally admirable without being morally obligatory, why disagreement about donation can persist without irrationality, and why the legitimacy of transplantation depends not only on legal safeguards but also on institutional character. The analysis remains attentive to Orthodox theological concerns about death, bodily integrity, and apophatic restraint, while proposing a non-triumphalist ethical vocabulary capable of supporting morally credible transplantation practices under conditions of pluralism and uncertainty.
Key words: Organ donation and transplantation, Kantian ethics, Virtue ethics, Neo-Aristotelianism, Orthodox theology, Moral formation, Brain death

Introduction

In an earlier analysis of Romania's continuing deadlock over post-mortem organ donation from brain-dead persons, it was argued that a Kantian-inspired dialogical framework can help mediate between Orthodox spiritual concerns and the life-preserving aims of transplantation medicine. The force of that argument lay in a structural affinity: Kant's critical philosophy, like Orthodox apophaticism, insists on the limits of what

may be claimed as knowledge,[1] especially where empirical medical criteria are burdened with metaphysical or spiritual certainty about death.[2]

What now needs development is not a change of ethical framework, but an enlargement of moral vocabulary. If the debate remains confined to duty, sanctity, prohibition, and permission, it fails to account for the slow formation of trust, judgment, and moral sensibility within communities. The question is not only whether organ donation can be justified in principle, but how it may become intelligible as a morally serious practice under conditions of grief, distrust, and spiritual hesitation.

This issue is especially pressing in Romania's post-pandemic context. As argued elsewhere, diminished confidence in medical institutions, together with recent public positions of the Romanian Orthodox Church that appear more receptive to paired organ donation than to deceased donation, has direct consequences for heart and liver transplantation, which generally depend on organs retrieved after death.[3] If the Church continues to function as a trusted moral authority for many believers, then the question is not whether it should replace medicine, but what kind of ethical language might support responsible discernment about medical facts, human vulnerability, and the ends of care.

This article therefore retains the Kantian framework as its normative boundary-setting structure, while using neo-Aristotelian virtue ethics as a complementary account of moral formation, practical judgment, and institutional credibility. Kantian ethics remains indispensable in setting moral limits: persons must not be instrumentalized, consent cannot be bypassed, and human dignity is non-negotiable.[4] Yet a duty-

[1] In a recent insightful analysis of Kant's view on the limits of knowledge, Edvardas Rimkus notes that, according to the great German philosopher, "[k]nowledge achieved by scientific methods is not complete or final, but only partial knowledge of some aspects of the objects of cognition". (Rimkus, E., 2023. The Question of the Limits of Cognition in Kant's Philosophy. *Studia Philosophica Kantiana*, 12(1), p. 28.)

[2] Băluțescu, R., 2024. Matters of Life or Death: Spiritual Obstacles to Organ Donation in Contemporary Romania. Towards a Kantian-Inspired Dialogical Framework for Breaking the Deadlock. *Cogito*, XVI(4).

[3] Ibid.

[4] Kant's Formula of Humanity requires that persons always be treated as ends in themselves and never merely as means. Applied to donation ethics, this supports the centrality of valid consent and the rejection of instrumentalization. (Kant, I., 1998. *Groundwork of the Metaphysics of Morals*. Ed. and trans. Gregor, M. Cambridge: Cambridge University Press, Ak. 4:429); Onora O'Neill develops a contemporary Kantian account of autonomy grounded less in preference satisfaction than in principled agency, trust, and non-deception—highly relevant to informed consent in medicine. (O'Neill, O., 2002. *Autonomy and Trust in Bioethics*. Cambridge: Cambridge University Press.)

based framework alone says too little about moral psychology, about the cultivation of trust, and about the virtues required of clinicians, families, institutions, and communities.[5] Virtue ethics helps address this lack by shifting attention toward character, practical wisdom, affective formation, and the institutional habits that make ethical practices credible.

Therefore, the present paper develops a dialogue between Kantian ethics, neo-Aristotelian virtue ethics, and Orthodox moral concerns in order to clarify the ethical conditions under which organ donation may be responsibly proposed, meaningfully understood, and legitimately refused. Our aim is deliberately limited. We do not offer a comprehensive account of transplantation ethics, nor do we claim to resolve longstanding controversies surrounding brain death, bodily integrity, or post-mortem beneficence. Rather, we seek to identify a more adequate moral vocabulary for thinking about organ donation in societies where law, medicine, religion, and historical distrust remain deeply entangled.

By "neo-Aristotelian virtue ethics" we do not mean a single unified school, but a family of contemporary approaches that retrieve Aristotelian themes of character, habituation, practical wisdom, flourishing, and the moral formation of practices. The article uses this family of approaches in a deliberately delimited way. To make this delimitation explicit, we draw selectively on authors whose work illuminates different dimensions of this shared Aristotelian inheritance. MacIntyre is relevant primarily for his account of practices, institutions, internal goods, and tradition-dependent rationality; Annas for her understanding of virtue as intelligent, developmental practical skill; Nussbaum for her attention to flourishing, vulnerability, and the concrete conditions under which human capacities can be exercised; and Pellegrino for his account of medicine as a moral practice ordered toward the good of the patient. These approaches differ significantly, and the article does not attempt to synthesize them into a complete theory. It draws on their shared Aristotelian grammar only insofar as it helps clarify the moral ecology of organ donation: the formation of trust, the exercise of judgment, the moral character of institutions, and the difference between admirable donation and compulsory moral duty.

[5] Edmund Pellegrino argues that medicine is inherently a moral practice ordered toward the good of the patient, not merely a technical service. (Pellegrino, E. D.,Thomasma, D. C., 1993. *The Virtues in Medical Practice*. New York: Oxford University Press.)

1. Kantian Limits, Orthodox Discernment, and the Need for Moral Formation

Neo-Aristotelian virtue ethics is a promising partner for the Kantian register of dignity, autonomy, and duty because it directs ethical attention to the terrain on which public controversies actually unfold: character, trust, exemplarity, emotion, and judgment. This is not a rejection of Kant. It is an attempt to supply what rule-centered debate often lacks—an account of how communities come to form stable dispositions such as generosity, compassion, courage, honesty, and justice, and how these dispositions make certain actions recognizable as morally fitting even in circumstances marked by loss and metaphysical uncertainty.

In this respect, virtue ethics can function as the moral psychology of the earlier dialogical framework. It explains how a culture capable of sustaining donation depends on more than propositions, prohibitions, or legal structures.[6] Contemporary transplant ethics increasingly moves in this direction. In a recent debate in *Medicina Intensiva*, del Rio Gallegos and colleagues stress that professionals involved in organ donation do not cease to be moral agents when they follow protocols. Whether organ donation is handled well cannot be decided only by checking that the right steps were followed. Much also depends on character, seasoned judgment, and sensitivity to the realities of the case in front of those involved. Cases rarely repeat themselves.[7]

That claim is structurally neo-Aristotelian. In morally complex situations, good practice cannot be reduced to compliance. It depends on cultivated judgment. This point is especially important in Romania, where public resistance to transplantation cannot be addressed only by legal clarification or medical information. Orthodoxy itself is a tradition of formation, habituation, exemplarity, and ascetic discipline. It is therefore not alien to virtue language, even where it remains skeptical of abstract bioethical discourse. A virtue-based ethical idiom may thus prove more intelligible than one framed exclusively in terms of autonomy or utility.

One important bridge between virtue ethics and transplantation is already visible in David M. Shaw's proposal that post-mortem organ

[6] Băluțescu, R., 2024. Matters of Life or Death: Spiritual Obstacles to Organ Donation in Contemporary Romania. Towards a Kantian-Inspired Dialogical Framework for Breaking the Deadlock, ibid.

[7] del Rio Gallegos, F., Escribá Bárcena, A., Grau Carmona, T., Mateos Rodriguez, A., 2025. The organ donation process: An ethical commitment. *Medicina Intensiva*, 49, p. 115.

donation may be understood as a "virtuous death," one that mitigates the moral misfortune of sudden death through a form of eudaimonic continuity extending into the lives one helps preserve.[8] Shaw's point is not sentimental. He does not deny the tragedy of death; rather, he suggests that donation can be interpreted as an act continuous with a person's practical identity and commitments. Read alongside Kantian respect for persons, this helps explain why donation need not be seen merely as the "use" of a body, but can sometimes be understood as a final expression of beneficence—provided that dignity and consent remain intact.[9]

2. Altruism, Motivation, and the Moral Boundaries of Donation

A major fault line in contemporary transplant ethics concerns the place of altruism. Gregory Moorlock, Jonathan Ives, and Heather Draper have shown that altruism often functions less as a neutral moral ideal than as a gatekeeping device that determines which motivations count as ethically acceptable and which are excluded from policy recognition.[10] Their critique is important because it exposes how transplant discourse sometimes presupposes an unrealistic image of moral purity.

Insisting on "pure altruism" as the only acceptable motivational basis for donation risks distorting how moral agency actually works. Human action is often shaped by mixed motives: love, family loyalty, gratitude, reciprocity, grief, a wish to create meaning out of suffering, or a desire to honor the values of the deceased. From a neo-Aristotelian perspective, this complexity is not ethically suspect in itself. Virtues are not defined by motivational sterility, but by the capacity of practical reason to orient action toward appropriate goods in concrete circumstances.

This is particularly helpful when placed alongside Kantian worries about instrumentalization. Kantian ethics rightly resists any framework in which persons are treated merely as means. But it does not follow that only motivations free of affective or relational entanglement are morally

[8] Shaw, D. M., 2017. A virtuous death: Organ donation and eudaimonia. *Bioethical Inquiry*, 14, pp. 319–321.

[9] Kant distinguishes duties of right from duties of virtue and includes beneficence among the latter: we ought to adopt others' permissible ends as ends of our own. This offers a Kantian basis for viewing donation as morally admirable without making it strictly compulsory. (Kant, I., 1996. *The Metaphysics of Morals*. Ed. and trans. Gregor, M. Cambridge: Cambridge University Press.)

[10] Moorlock, G., Ives, J., Draper, H., 2014. Altruism in organ donation: an unnecessary requirement? *Journal of Medical Ethics*, 40(2), pp. 134–138.

acceptable. The critique offered by Moorlock and colleagues allows us to distinguish more clearly between morally problematic incentives and morally intelligible reasons for donation. Neo-Aristotelian virtue ethics thus broadens the moral anthropology of the debate without weakening the central Kantian concern for respect.[11]

This also explains why the present article resists both extremes: the reduction of donation to a merely optional private preference and the elevation of donation into a universal moral requirement. Virtue ethics allows donation to be described as morally admirable when it expresses generosity, fidelity, and practical wisdom, while Kantian ethics prevents admiration from becoming coercive expectation.

3. Commodification and the Virtue Ethics of Gifts

The distinction between donation and sale remains one of the most revealing tests for any ethical approach to transplantation. Several phenomenological and theological accounts of the gift, including those associated with Jean-Luc Marion, have emphasized that giving and receiving at the threshold of death cannot be adequately described in market terms.[12] On such views, donation exceeds simple exchange. It bears meanings of gratuity, self-giving, and relational asymmetry that cannot be captured by the language of equivalence.

At the same time, this phenomenology of the gift also reveals the ethical ambivalence of receiving. A gift of such magnitude may generate gratitude, but also guilt, indebtedness, and a sense of asymmetrical obligation. The recipient may experience donation not only as rescue, but as a burden of unpayable debt. In some accounts, transplantation even acquires a symbolic or spiritual dimension in which donor and recipient are imagined as joined through the act of transfer.[13] Whether or not one endorses such interpretations, they show that the moral meaning of donation cannot be exhausted by procedural notions of consent and allocation.

Barbro Björkman's Aristotelian analysis of organ markets is especially useful here. She argues that the wrongness of organ selling cannot be reduced simply to exploitation. More fundamentally, markets corrupt social practices that ought to be ordered by virtues such as generosity

[11] Ibid.
[12] Marion, J.-L., 1991. *God without Being*. Chicago: University of Chicago Press.
[13] Ibid.

and justice.[14] From this point of view, donation is not morally valuable merely because it is unpaid. It is valuable because it belongs to a practice structured by common goods, trust, and moral recognition. Virtue ethics therefore provides a principled, though not simplistic, basis for rejecting commodification while still allowing nuanced discussion of support, recognition, and non-market forms of compensation.

4. Relational Ethics in Practice: Families, Clinicians, Trust, and Consent

The ethical quality of organ donation is inseparable from the quality of the relationships that sustain it. This is one of the clearest lessons of the nursing ethics literature. Families of deceased donors are not merely consent-givers who appear at the end of a medical process. They are moral participants attempting to navigate grief, uncertainty, responsibility, and meaning. The narrative review in *Nursing Ethics* stresses relational continuity, truthfulness, prudence, and compassionate accompaniment as central to ethically sound support for potential donors' relatives.[15]

Here, the complementarity of Kantian and neo-Aristotelian approaches becomes particularly visible. Kantian ethics secures the minimum moral boundaries of transplantation: no donation without respect for persons, no acceptable practice without dignity, and no legitimacy where consent is manipulated or ignored.[16] Virtue ethics explains how those moral boundaries become livable and credible in concrete settings. In societies such as the Romanian one, where public trust is mediated by religious and communal narratives, this distinction matters. Rules may authorize a practice, but they do not by themselves make it morally intelligible. This point can also be framed in Kantian terms, since moral formation is not exhausted by theoretical assent to duty. As Andrea Miškocová writes, "Morality is not a mere theoretical base but a place from which practical virtuous action begins. It is not enough to speak of the individual acting morally only for himself. The consequences

[14] Björkman, B., 2008. *Virtue Ethics, Bioethics, and the Ownership of Biological Material*. PhD dissertation. Stockholm: KTH Royal Institute of Technology.

[15] Baumann, A., Thilly, N., Joseph, L., Claudot, F., 2022. Ethical Reflection Support for Potential Organ Donors' Relatives: A Narrative Review. *Nursing Ethics*, 29(3).

[16] In her apt account of Kant's connection between duty, virtue and dignity, Andrea Miškocová writes: "The attainment of virtue is not merely a possibility for man, but his inner duty, for it exists in man not only as a prerequisite of his freedom, but as a power which is acquired by the contemplation of the dignity of the rational law and the practice of virtue." (Miškocová, A., 2024. Moral Formation in Kant's Philosophy. *Studia Philosophica Kantiana*, 13(2), p. 232.

of his actions are cosmopolitan, manifesting themselves at the level of society."[17]

A virtue-based perspective also opens a productive dialogue with Orthodox moral anthropology, which has traditionally emphasized formation more than isolated rule-following. Orthodox ethics, like Aristotle's, is concerned with the shaping of persons through repeated practices, exemplars, and communal rhythms. This may help explain why appeals framed only in terms of autonomy or efficiency often leave Orthodox believers unconvinced in matters of organ donation, whereas narratives centered on self-giving, responsibility, and faithful care tend to carry greater moral force. In this respect, Aristotle's language of *hexis* (charity) offers a useful conceptual bridge for interpreting donation not as a technocratic intervention at the end of life, but as a possible extension of a life oriented toward love of neighbor.[18]

The role of moral exemplars is central here. Virtue ethics has long held that people learn morally not only from principles but from lives that render the virtues visible**.** In the setting of organ donation, such exemplars might be donor families who speak of donation as a meaningful way of responding to loss, or clinicians who show honesty, restraint, and compassion in end-of-life care.

Contemporary virtue ethics can make the same point without relying on an analogy external to bioethics: moral judgment is shaped not only by rules and outcomes, but also by the perceived character of agents, the intelligibility of their motives, and the narrative coherence of their conduct. In transplantation contexts, this matters because families and communities assess not only whether professionals have followed a protocol, but whether their conduct displays honesty, restraint, compassion,

[17] Ibid., p. 228.

[18] Aristotle describes moral virtue as a *hexis*: a relatively stable disposition of character, expressed in choice and guided by reason toward an appropriate mean (NE II.6, 1106b36–1107a2). Read in this light, donation need not be understood as a single detached gesture. It can instead be seen as the outward sign of a formed character, one schooled in generosity and responsive to what the situation rightly calls for. (Aristotle, 2009. *The Nicomachean Ethics*. Trans. Ross, W. D., rev. Brown, L. Oxford: Oxford University Press); Martha Nussbaum observes that, for Aristotle, ethical excellence cannot be measured by occasional good deeds taken one by one. It belongs instead to a character gradually formed through habituation, sound judgment, and a sensitive response to particular circumstances. Seen in this way, *hexis* is better understood as a durable moral orientation than as a mere routine or automatic habit. (Nussbaum, M. C., 2001. *The Fragility of Goodness: Luck and Ethics in Greek Tragedy and Philosophy*. Rev. ed. Cambridge: Cambridge University Press, esp. pp. 290–318.)

and fidelity to the good of the patient.[19]

When transplant practices are not connected to recognizable virtues, they are more likely to arouse moral suspicion, even when they comply with legal and procedural requirements. This becomes especially important in post-mortem donation, where the donor can no longer speak and surviving relatives must often reconstruct the meaning of the act. Families need more than procedural explanation; they often need reassurance that donation is faithful to the life and values of the deceased. In that respect, the healthcare professional is not simply an administrator of consent, but also a moral witness whose conduct may help a family understand donation as an ethically coherent act rather than an extraction performed under institutional pressure.[20]

The concept of *phronēsis* is crucial here. Practical wisdom is not a method for reaching final answers, but a virtue of context-sensitive discernment.[21] This matters not only for clinicians but also for dialogue between medicine and religious authority. When churches are asked to pronounce definitively on complex questions such as brain death or procurement protocols, a virtue-based perspective supports a more modest and dialogical role: one that articulates moral concerns, acknowledges epistemic limits, and engages medical expertise without claiming exhaustive competence.[22]

The same virtue-based framework also helps make sense of the erosion of public trust in healthcare institutions. Trust is not produced by regulation alone. The same virtue-based framework also helps make sense of the erosion of public trust in healthcare institutions. Trust is not produced by regulation alone. This is especially important in post-communist societies, where institutional memory includes coercion, opacity, and suspicion. In the Romanian case, mistrust of organ donation should not be dismissed as mere ignorance. It is historically shaped and morally charged. Virtue ethics allows these suspicions to be taken seriously without granting them automatic authority. It treats them as signals of

[19] Annas, J., 2011. *Intelligent Virtue*. Oxford: Oxford University Press; MacIntyre, A., 2007. *After Virtue*. 3rd ed. Notre Dame, IN: University of Notre Dame Press.; Pellegrino, E. D., Thomasma, D. C., 1993. The Virtues in Medical Practice, ibid.

[20] Baumann, A., Thilly, N., Joseph, L., Claudot, F., 2022. Ethical Reflection Support, ibid.

[21] Julia Annas interprets virtue as intelligent skill-like development rather than rule compliance, making her especially relevant to clinical judgment and moral formation. (Annas, J., 2011. *Intelligent Virtue*, ibid.)

[22] Băluțescu, R., 2024. Matters of Life or Death: Spiritual Obstacles to Organ Donation in Contemporary Romania. Towards a Kantian-Inspired Dialogical Framework for Breaking the Deadlock, ibid., pp. 24, 25.

damaged civic trust rather than as irrational obstacles to be swept away.

A sociological perspective reinforces this point. Talcott Parsons famously described illness as a form of "legitimate deviance" within the social system: a condition that suspends ordinary obligations while placing the individual under the authority of medicine.[23] Organ failure is thus not only a biological crisis but a disruption of social participation. Transplantation appears, within this framework, as a mechanism of restoration. Yet that same restorative authority can become morally suspect when it is experienced as domination rather than care. Read alongside virtue ethics, Parsons' analysis suggests that institutions do not earn trust merely by fulfilling technical functions.

Authority by itself does not generate public trust. Trust develops when institutional power is perceived to serve care, fairness, and shared benefit rather than simple control.[24] Recent sociological research points in much the same direction. Resistance to organ donation often appears to arise not only from private religious conviction, but from mistrust and weakened relations between citizens and institutions. One qualitative study carried out in a predominantly religious context reported that family refusal was associated more strongly with distrust of healthcare systems, poor communication, and limited public recognition of donors than with doctrine itself. In that setting, religion more often shaped how institutional conduct was interpreted than directly caused refusal.[25] Although these findings cannot simply be transferred to Romania, they illuminate structurally comparable dynamics in contexts where religion, family consent, and institutional credibility remain closely intertwined.

The same is true of broader proposals for a "sociology of donation." Such approaches remind us that donation is not a discrete act motivated by individual altruism alone, but a socially embedded practice shaped by norms, narratives, and institutional arrangements.[26] Sociology does

[23] Parsons, T., 1951. Illness and the Role of the Physician: A Sociological Perspective. *American Journal of Orthopsychiatry*, 21(3); Parsons, T., 1967. *Sociological Theory and Modern Society*. New York: Free Press.

[24] Alasdair MacIntyre's account of practices and virtues helps explain why institutions require internal goods and moral excellences, not only external regulation. (MacIntyre, A., 2007. *After Virtue*, ibid.)

[25] Lalehgani, H., Babaee, S., Yazdannick, A. R., Alimohammadi, N., Saneie, B., Ramezannejad, P., 2024. Explanation of the sociological patterns of organ donation: An analytical study. *Journal of Education and Health Promotion*, 13(87).

[26] Machin, L. L., Williams, R. A., Frith, L., 2020. Proposing a sociology of donation: The donation of body parts and products for art, education, research, or treatment. *Sociology Compass*, 14, e12826.

not replace ethics here. Rather, it clarifies how trust, suspicion, generosity, and reluctance are socially formed, while Kantian and neo-Aristotelian ethics remain necessary to assess what is morally permissible and admirable within those practices.

This broader perspective also deepens our understanding of consent. Kantian bioethics rightly insists that consent is a threshold condition. Yet virtue ethics directs attention to the circumstances under which consent becomes ethically meaningful. The law may accept consent given in moments of pressure, confusion, loneliness, or mistrust. Ethics may hesitate. Consent formed through respectful, truthful, unhurried conversation has greater moral force and better reflects institutional *phronēsis*.[27] Consent, in other words, is not merely a formal event but a relational process.[28]

The same applies to vulnerability. A virtue-ethical approach does not treat vulnerability simply as a factor triggering additional safeguards, though such safeguards remain important. It treats vulnerability as a familiar part of human life, one that calls for gentleness, patience, honesty, and courage. The more serious moral failure lies not in vulnerability itself, but in neglecting it, exploiting it, or turning it into an instrument of pressure. This insight also helps explain why critiques of reductive altruism matter. Moral value does not arise from denying vulnerability, but from responding to it well.[29]

Taken together, these lines of argument suggest that the future ethical credibility of transplantation depends less on achieving final metaphysical agreement than on cultivating moral reliability. Kantian ethics establishes the inviolability of persons; neo-Aristotelian ethics explains how respect becomes believable in practice.[30] In societies negotiating between religious tradition, historical trauma, and modern medicine, ethical reform is therefore likely to be slow, relational, and practice-based rather than rhetorically decisive.

[27] Baumann, A., Thilly, N., Joseph, L., Claudot, F., 2022. Ethical Reflection Support, ibid.

[28] Kant repeatedly links rightful interaction with the independence of each person's choice under universal law. In modern bioethics, informed consent can be read as one institutional expression of that requirement. (Kant, I., 1996. *The Metaphysics of Morals*, ibid.)

[29] Moorlock, G., Ives, J., Draper, H., 2014. Altruism in organ donation, ibid.

[30] Martha Nussbaum links respect for persons with the real possibility of flourishing through concrete capabilities rather than abstract recognition alone. (Nussbaum, M. C., 2011. *Creating Capabilities*. Cambridge, MA: Harvard University Press.)

5. Bodily Integrity, Grief, and Meaning-Making After Death

Concerns about bodily integrity after death remain among the most persistent spiritual and cultural obstacles to organ donation. Within Orthodox contexts, these concerns are often expressed not in the language of biology but in that of reverence: the body is regarded as bound up with personhood, death, mourning, and resurrection, not as inert material available for technical use. A neo-Aristotelian approach can help clarify that respect for bodily integrity need not entail absolute bodily inviolability. The moral question is not whether the body may undergo alteration after death, but whether such alteration occurs within a practice ordered toward genuine human goods and governed by restraint, dignity, and consent.[31]

Parsons' sociological framework is illuminating here as well. If health is socially coded as a condition of functional participation, then the body also carries symbolic meaning that exceeds its biological status. Post-mortem bodily integrity may therefore represent continuity of identity, not merely physical completeness.[32] Transplantation confronts not only biological death but also the cultural and spiritual significance of the body. Any ethically serious engagement with organ donation must therefore acknowledge that the body functions both as biological substrate and as bearer of collective and religious meaning.

Virtue ethics also helps temper the moral language often used in this area. Generosity, sacrifice, and courage are real virtues, but they can be badly misused if romanticized. Giving is not always good simply because it is costly. Contemporary virtue theory insists that generosity is a mean, not a cult of self-erasure. In post-mortem donation, where the primary moral agent is no longer present and others must interpret the meaning of the act, ethical legitimacy depends not on heroic sacrifice but on prudent and faithful interpretation supported by trustworthy institutions.[33]

Björkman's distinction between donation and sale reinforces this point. Similar physical acts may be morally understood in radically different ways depending on the practice in which they are embedded. When transfer is governed by profit, moral perception is distorted. When

[31] Băluțescu, R., 2024. Matters of Life or Death: Spiritual Obstacles to Organ Donation in Contemporary Romania. Towards a Kantian-Inspired Dialogical Framework for Breaking the Deadlock, ibid., p. 12.
[32] Parsons, T., 1967. *Sociological Theory and Modern Society*, ibid.
[33] Moorlock, G., Ives, J., Draper, H., 2014. Altruism in organ donation, ibid.

it is structured by trust, shared goods, and respect, donation can be seen as morally intelligible rather than corrupting. This is why public narratives matter so much.[34] If organ donation is presented only as a technical answer to scarcity, it may appear cold, managerial, or utilitarian. If it is presented through truthful narratives that integrate loss, love, gratitude, and responsibility, it becomes more recognizably human.[35]

Yet such narratives must remain restrained. Virtue ethics rejects manipulation, even when deployed for apparently noble ends. Overidealized portrayals of donation can produce backlash, particularly in societies already suspicious of institutional motives. Practical wisdom requires attention to moral readiness. Some communities may need time, transparency, and repeated experiences of trustworthy practice before donation can be received as a virtue rather than as a threat. In this sense, moral patience is not peripheral to transplantation ethics; it is one of its central, if neglected, virtues.

6. Moral Responsibility, Reciprocity, and Institutional Ethics

Neo-Aristotelian virtue ethics treats responsibility as relational rather than as a burden borne by isolated individuals. In the context of transplantation, responsibility is distributed across donors, families, clinicians, institutions, policymakers, and the wider civic culture. Autonomy remains indispensable, but it is never exercised outside practices that either sustain or erode responsible choice. This is particularly important in transplantation, where no single actor controls the entire moral field.

The same relational logic applies to reciprocity. Critics sometimes fear that appeals to reciprocity place covert pressure on citizens by implying that one owes donation to the community. Virtue ethics helps avoid this distortion. Reciprocity need not mean moral accounting. It can instead name a shared orientation toward sustaining practices that protect common goods. Properly understood, reciprocity is not a demand imposed on vulnerable individuals, but a recognition that flourishing depends on forms of mutual participation that no one creates alone.[36]

This perspective also changes how we evaluate opt-in and opt-out systems. Policy debates often focus on effectiveness and donation rates. Virtue ethics asks a deeper question: what sorts of moral dispositions are

[34] Björkman, B., 2008. *Virtue Ethics, Bioethics, and the Ownership of Biological Material*, ibid., p. 21.
[35] Baumann, A., Thilly, N., Joseph, L., Claudot, F., 2022. Ethical Reflection Support, ibid., pp. 672–673.
[36] Moorlock, G., Ives, J., Draper, H., 2014. Altruism in organ donation, ibid., p. 136.

cultivated by a given consent regime? An opt-out system may increase procurement while weakening trust if it is perceived as appropriation. An opt-in system may yield slower gains while better respecting agency if it is supported by long-term moral education and transparent institutional practice. Legal architecture therefore cannot be assessed solely by outcomes detached from moral formation.[37]

This caution is especially important in contexts marked by fragile public trust. Legal reform cannot compensate for institutional opacity. Where citizens suspect self-interest, coercion, or disregard for the dead, they are unlikely to experience presumed consent as an expression of solidarity. They may instead experience it as moral overreach. Virtue ethics interprets such reactions not as irrationality pure and simple, but as evidence that institutions have failed to display the character required to make their authority credible. Laws can authorize practice; only moral reliability can secure legitimacy.

Parsons' analysis sharpens this point. If medicine operates as a system of social regulation designed to manage disruption and restore functional participation, transplantation occupies a structurally delicate position. It combines restoration with exceptional power over the threshold between life and death.[38] When this power is exercised transparently and justly, it can reinforce social trust. When it appears opaque or self-serving, it risks being perceived as domination. The ethical stakes of transplantation are therefore never only clinical; they are also civic and institutional.

Grief belongs within this institutional picture. It is not an external difficulty that interrupts otherwise rational decision-making. It is one of the central moral contexts in which post-mortem donation occurs. Virtue ethics resists marginalizing grief. It insists that grief calls forth specific virtues from professionals and institutions: truthfulness, patience, compassion, restraint, and attentiveness. Decisions made in grief are not morally defective because emotion is present. Their ethical quality depends on whether grief is met with practical wisdom or with procedural insensitivity.[39]

From this perspective, organ donation can sometimes become part of moral repair. It does not redeem death, nor does it transform refusal into failure. But it may help some families integrate loss into a narrative

[37] MacIntyre, A., 2007. *After Virtue*, ibid.
[38] Parsons, T., 1967. *Sociological Theory and Modern Society*, ibid.
[39] Shaw, D. M., 2017. A virtuous death, ibid., pp. 320–321.

that affirms shared goods and relational continuity.

What matters ethically is not whether donation always brings healing, but whether families are treated as moral agents whose decisions deserve respect in moments of vulnerability. That insistence on acknowledgment resonates strongly with Kantian respect for persons while avoiding the level of abstraction that can distance grieving families.

The question of posthumous beneficence also becomes easier to frame within virtue ethics. Kantian ethics has difficulty with the idea of agency after death, whereas virtue ethics understands beneficence as continuous with the orientation of a person's life rather than as a discrete act performed by a presently acting subject. On this view, postmortem donation can be seen as morally continuous with virtues cultivated during life, without requiring doubtful metaphysical claims about the ongoing interests of the dead.[40]

Practices of remembrance and acknowledgment have significance as well. Public recognition of donors and respectful communication with families are not merely symbolic gestures. They disclose institutional character and can sustain trust and gratitude without recasting donation in market terms.[41] Where such acknowledgment is absent, even procedurally acceptable donation may later be interpreted as violation. The ethics of transplantation is inseparable from the ethics of mourning.

7. Moral Disagreement, Epistemic Humility, and the Limits of Ethical Consensus

Among the more important contributions neo-Aristotelian virtue ethics can offer transplant ethics is a disciplined sense of epistemic humility. In matters marked by grief, uncertainty, and deep pluralism, ethics should resist the temptation of finality. Humility here is not indecision. It is the recognition that disagreement may persist even among informed and morally serious persons, and that overconfident judgment may itself become a moral fault.[42]

This humility fits well with the Kantian dimensions of the earlier dialogical framework. Kantian ethics does not guarantee agreement in every case. It sets limits designed to block moral overreach: persons

[40] Băluțescu, R., 2024. Matters of Life or Death: Spiritual Obstacles to Organ Donation in Contemporary Romania. Towards a Kantian-Inspired Dialogical Framework for Breaking the Deadlock, ibid., p. 13.

[41] Baumann, A., Thilly, N., Joseph, L., Claudot, F., 2022. Ethical Reflection Support, ibid., p. 673.

[42] Moorlock, G., Ives, J., Draper, H., 2014. Altruism in organ donation, ibid., p. 134.

must never be treated merely as means, consent cannot be bypassed, and dignity remains inviolable. In the context of organ donation, this means that dissent should not automatically be dismissed as irrational or morally backward. Refusal may instead reflect a different moral ontology rather than simple ignorance.[43]

From a neo-Aristotelian perspective, moral disagreement often arises from differing conceptions of the human good rather than from factual mistake alone. This is especially true in transplantation, where death, bodily integrity, generosity, and care are interpreted within different religious, cultural, and historical frameworks. An ethics that ignores these differences risks becoming imperial in tone, even when its substantive aims are benevolent.[44]

Parsons' account of health as culturally mediated reinforces this insight. Health and illness are not interpreted in social life in purely biological terms. They are shaped, too, by wider values and inherited assumptions that influence how people interpret flourishing, normal functioning, and the integrity of the body.[45] In communities where bodily wholeness after death is tied to sacred embodiment or resurrection, the language of functional restoration may fail to persuade. In such cases, ethical disagreement is often normative rather than merely informational.

The nursing ethics literature supports this point by showing that families and professionals frequently disagree not only about facts, but also about meanings: what donation signifies, what obligations continue after death, and what counts as respect.[46] Efforts to settle such disagreements through scripts, slogans, or procedural authority may deepen mistrust instead of easing it. Virtue ethics interprets this not as a reason to abandon ethical guidance, but as evidence that moral consensus cannot be manufactured without attending to interpretation, narrative, and relational context.

This has consequences for public policy. If reasonable disagreement is likely to persist, then policy should aim less at unanimity than at legitimacy under disagreement. A transplant system should be capable of functioning ethically even where participation remains partial, con-

[43] Bălușescu, R., 2024. Matters of Life or Death: Spiritual Obstacles to Organ Donation in Contemporary Romania. Towards a Kantian-Inspired Dialogical Framework for Breaking the Deadlock, ibid., p. 7.
[44] Björkman, B., 2008. *Virtue Ethics, Bioethics, and the Ownership of Biological Material*, ibid.
[45] Parsons, T., 1967. *Sociological Theory and Modern Society*, ibid.
[46] Baumann, A., Thilly, N., Joseph, L., Claudot, F., 2022. Ethical Reflection Support, ibid.

tested, and morally diverse. Virtue ethics supports such an approach by prioritizing trustworthiness over maximal compliance.[47]

The same applies to public discourse. Campaigns that assume inevitable convergence on one moral view tend to underestimate the depth of pluralism. A virtue-based approach, by contrast, leaves room for the possibility that some disagreements endure because they arise from moral frameworks that are internally coherent yet incompatible with one another.[48] Recognizing this does not weaken ethics. It disciplines it. It limits the moral authority of persuasion and underscores the importance of restraint.

Professional ethics is equally implicated. Clinicians and transplant coordinators often speak from positions of asymmetrical knowledge and authority. Virtue ethics would hold that authority of this sort should be exercised with an awareness of its own boundaries. Ethical excellence is shown less by securing consent quickly than by knowing when to pause, clarify, listen with care, and sometimes refrain from further pressure.[49] Such restraint is not administrative failure; it is a professional virtue grounded in respect for moral agency under conditions of uncertainty.

The model proposed here is not limited in principle to Orthodox contexts, although its theological vocabulary would require careful translation. Its transferable element is not a specifically Orthodox doctrine of the body, but the combination of Kantian limits, virtue-based moral formation, and dialogical restraint under conditions of metaphysical disagreement. In Jewish and Islamic ethics, for example, questions of bodily integrity, the sanctity of life, post-mortem respect, communal obligation, and the authority of legal-religious interpretation are articulated through different conceptual grammars.[50] A responsible extension of the present framework would therefore not impose Orthodox categories on those traditions, but would ask analogous questions: what counts as respect for the body, how consent and family authority are understood, how life-saving benefit is weighed against post-mortem integrity, and

[47] Moorlock, G., Ives, J., Draper, H., 2014. Altruism in organ donation, ibid.

[48] Björkman, *Virtue Ethics, Bioethics, and the Ownership of Biological Material*, ibid.

[49] Dalal, A. R., 2015. Philosophy of organ donation: Review of ethical facets. *World Journal of Transplantation*, 5(2), pp. 44–51.

[50] Tarabeih, M., Marey-Sarwan, I., Amiel, A., Na'amnih, W., 2025. Posthumous Organ Donation in Islam, Christianity, and Judaism: How Religious Beliefs Shape the Decision to Donate. *Omega*, 92(1); Bokek-Cohen, Y., Abu-Rakia, R., Azuri, P., Tarabeih, M., 2022. The View of the Three Monotheistic Religions Toward Cadaveric Organ Donation. *Omega*, 85(2); Padela, A. I., Auda, J., 2020. The Moral Status of Organ Donation and Transplantation Within Islamic Law: The Fiqh Council of North America's Position. *Transplantation Direct*, 6(3), e536.

which virtues institutions must display in order to become trustworthy. The framework is therefore transferable only at the level of method: it offers a way of structuring dialogue among dignity, vulnerability, practical wisdom, and religiously formed moral meaning, not a ready-made substantive conclusion for all traditions. Such transferability is modest but important: it concerns the ethics of translation between moral worlds, not the export of a single theological solution.

None of this entails relativism. Both Kantian and neo-Aristotelian approaches retain the ability to condemn coercion, deception, exploitation, and commodification. What humility limits is not moral judgment itself, but unwarranted claims to finality in situations where disagreement remains both reasonable and durable.[51] In transplantation ethics, that balance is especially fragile, since both overconfidence and excessive caution can do real harm. Virtue ethics does not remove this tension, but offers a way to navigate it through *phronēsis*: judgment that is sensitive to context and shaped by experience, reflection, and character rather than by algorithmic certainty.[52]

From this perspective, the enduring ethical credibility of organ donation depends less on complete agreement than on the ability of institutions and persons to act responsibly while disagreement remains unresolved. Epistemic humility strengthens ethical seriousness because it aligns moral ambition with the complexity of moral reality.

Conclusion

This article has argued that ethical reflection on organ donation is better served by a framework capable of sustaining responsible practice under conditions of uncertainty and pluralism than by the pursuit of definitive moral closure. The dialogue between Kantian ethics and neo-Aristotelian virtue ethics does not eliminate disagreement, nor does it promise universal endorsement of donation. What it offers instead is a more adequate moral vocabulary for explaining how organ donation may be responsibly proposed, legitimately refused, and publicly defended without distortion.[53]

Within this integrated framework, organ donation appears neither as a strict duty nor as a morally empty private option. Its ethical meaning

[51] Shaw, D. M., 2017. A virtuous death, ibid.
[52] Björkman, B., 2008. *Virtue Ethics, Bioethics, and the Ownership of Biological Material*, ibid.
[53] Ibid.

depends on how it is embedded within relationships, institutions, and forms of life. Kantian ethics places firm limits on treating persons merely as instruments. Virtue ethics, by contrast, helps explain how respect becomes visible in ordinary practice through character, trustworthy conduct, narrative coherence, and prudent judgment.[54] Without Kantian limits, virtue language can become morally overreaching. Without virtue, rule-based ethics can become cold, abstract, and institutionally unpersuasive.[55]

Organ donation concentrates tensions between autonomy and solidarity, vulnerability and agency, life-saving benefit and reverence for the dead. What emerges from this article is that ethical resilience depends less on consensus than on reliability over time: on institutions worthy of trust, on professionals who act with prudence and honesty, and on communities able to sustain serious moral disagreement without sliding into suspicion or coercion.[56]

For policymakers, clinicians, and religious communities alike, the challenge is therefore not to eliminate disagreement, but to act well within it. That requires transparency, narrative honesty, restraint, and moral education rather than persuasive urgency. Virtue ethics reminds us that ethical progress is measured not only by outcomes, but by the quality of the practices that produce them. Where trust is patiently cultivated and dignity consistently upheld, organ donation may come to be seen as morally intelligible without becoming morally compulsory.[57]

A morally credible transplant culture must therefore leave room not only for generous donation, but also for conscientious refusal. Refusal should not automatically be interpreted as ignorance, selfishness, or hostility to medicine; it may express grief, reverence for the body, distrust shaped by history, or a religiously formed understanding of death. The ethical task is not to erase such refusal, but to ensure that both donation and refusal occur within practices marked by truthfulness, patience, and respect.

The central claim of this follow-up remains deliberately modest. We do not argue that organ donation must be universally embraced, nor

[54] Kant's ethics does not deny the importance of sympathetic concern, but insists that moral worth lies in acting from duty while cultivating dispositions supportive of duty. This leaves room for humane professional conduct alongside principled limits. (Kant, I., 1997. *Lectures on Ethics*. Eds. Heath, P., Schneewind, J. B. Cambridge: Cambridge University Press.)

[55] Nussbaum, M. C., 2011. *Creating Capabilities*, ibid.

[56] Dalal, A. R., 2015. Philosophy of organ donation, ibid., p. 50.

[57] Moorlock, G., Ives, J., Draper, H., 2014. Altruism in organ donation, ibid.

that the ethical tensions surrounding it can be fully resolved. We argue only that a combined Kantian and neo-Aristotelian approach provides a richer and more realistic moral vocabulary for navigating those tensions without reductionism. By recognizing both the limits of ethical authority and the genuine possibility of moral excellence, this framework remains alert to the seriousness of death while also giving due regard to the moral hopes of those who continue living.[58]

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[58] Shaw, D. M., 2017. A virtuous death, ibid., p. 321.

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