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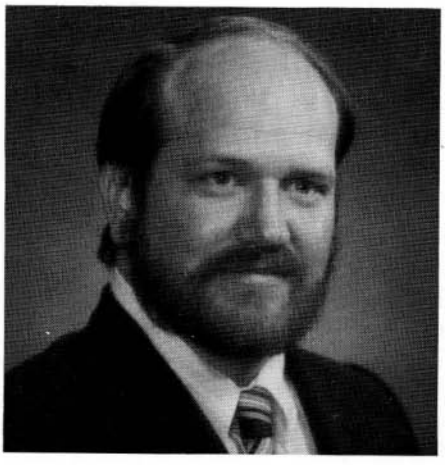

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Several salient moral issues surface vis-à-vis the AIDS problem. The intent of this article is to stimulate discussion by posing questions of a significant nature for hospitals, their personnel and constituencies. An attempt will be made to answer these questions within a (hopefully) coherent and consistent ethical framework, in order that a "scaffolding" might be developed for further debate and refinement.

Before doing so, a few remarks must be made concerning the distinction between legality and morality. Law is basically an abstraction from the morality of a given group of people and, therefore, laws necessarily have some moral underpinning and rationale. Nonetheless, there are differences between the two which are pertinent to the discussion.

Most laws deal with what is *obligatory,* particularly with obligations which are coupled with punishment and/or reparations of some sort. Although ethical theory inquires into the reasonable grounds for the *justification* of these legal obligations, it also deals with what is *supererogatory,* i.e., with actions which are praiseworthy to do, but not blameworthy not to do.[1] This distinction is particularly relevant to an ostensibly pluralistic and "secular" society. Legal obligations are binding on all citizens, regardless of specific religious and moral beliefs. Although an individual, in good conscience, may choose to disobey a positive law,

the state may still exert its right to compel obedience and to levy punishment. The realm of the supererogatory, however, is often viewed as the province of individual, voluntary religious perspectives. We like to keep the heroic and saintly free from compulsion and punishment, even if we admire it exceedingly.

It is also not too great a caricature of the law, ancient and modern, to say that it deals primarily with *negatives,* with "Thou shalt nots", while it is often the case that religious morality, for example, is full of *positive* commandments — to "go the second mile", etc.

In our lived moral experience, it is often hard to disentangle these distinctions, especially since our culture rests historically on many of the value assumptions of "Judeo-Christianity." The common moral assumptions of the "everyday person" are willy-nilly the inheritance of this tradition, and this fact contributes to much of the confusion and vehemence of contemporary moral debates. This is particularly problematic for religious hospitals, which must respect secular laws and "rights" while at the same time remaining faithful to their heritages. It is tempting to short-cut moral debate by referring exclusively to the requirements of the law — to merely prudential considerations often phrased in terms like "What will happen to me/us if I/we do/don't do such and such?" It is, however, possible that courts will increasingly look to medical experts for advice on matters as socially explosive and as empirically confusing as AIDS, thus putting medical institutions in the role of providing reasonable justification for such policies, whether or not they want to be in such a role.

It may be helpful to discuss AIDS from the standpoint of *responsibility and role.* Such a framework may be able to clarify some problems surrounding the distinction previously made between obligations binding on all citizens of a pluralistic society and those moral values which free citizens might voluntarily choose for themselves. The former may be called "natural law/social contract" ethics, and the latter religious ethics.[2]

This article will explore three role-specific areas of responsibility: 1) the responsibility of citizens, government and the afflicted; 2) the responsibility of hospital administration, specifically, of a religious hospital and 3) the responsibility of the physician/researcher and of other hospital personnel. There are obviously many overlaps here. This very fact reinforces the agony of the dilemma. Much of the "dilemma" aspect of the current AIDS debate comes from tensions inherent in these roles. Much of morality is, in fact, role-specific, and universal only with regard to the universal aspects of that role.[3] Such role-conditioned responsibilities may differ and even clash with each other. But looking at the problem through the "lens" of responsibility and role may help to shed some light on, and bring some order to, a very urgent and perplexing problem.

Responsibility of Citizens, Government and the Afflicted

It is somewhat odd, no doubt, to speak of the responsibility of the afflicted in a hospital context. Yet this particular area is hotly debated among the public, and the attitude of the public will put considerable pressure on politics and law. It may not prove to be irrelevant to those in positions of power within medical institutions, either.

It is sometimes assumed, by people acting solely out of an understanding of the secular, social contract view, that citizens are basically bearers of *negative rights* vis-à-vis the state. That is to say, the state "owes" them freedom from undue interference of various kinds. There is considerable truth to this position. The eminent philosopher, John Rawls, elucidates one of the principles of a liberal social order, based on social contract theory, as "maximum liberty compatible with like liberty for all."[4] The key problem, of course, is spelling out what is meant by "compatible," especially when we are dealing with AIDS. Though we can make a strong case that the *presumption* of the social contract is for individual freedom (i.e., the state bears the burden of proof in *reducing* freedom), this freedom cannot, obviously, be absolute. The state reserves the right to conscript persons for military service in the event of grave threat to the state, e.g., in wartime. The state will declare certain of an individual's rights to freedom forfeit should they prove to be incompatible with others, e.g., when that individual harms people. Certainly the state has the right, and has exerted the right historically, to abrogate personal rights in the event of massive social harm, such as an epidemic, through such measures as involuntary quarantine and isolation.[5]

AIDS may come to present a severe enough threat to public well-being to warrant measures such as mandatory testing and perhaps quarantine/isolation as well. It is important, however, that certain moral safeguards be met should such a situation arise.

The general moral obligation to "do no harm", taken, in the case of AIDS, in the even stronger sense of "do not kill", can, by even the strongest variety of legal positivism and secularism, be considered a fundamental negative of the natural law. In the thought of H. L. A. Hart, a late, great legal scholar, it can be considered a *functional requisite* for all societies, irrespective of religious or quasi-religious orientation.[6]

The transmission of the AIDS virus is obviously, on the basis of *consequences,* an act of harm, whether or not it is *willfully intended.* As such it can be considered grounds for the abrogation of specific rights to freedom, which may include such measures as quarantine/isolation and mandatory testing.

Testing

Having AIDS and knowing it, and refraining from telling an "innocent" party beforehand can easily be construed as an act of murder, (short of psychotic depression, or the sort of heroic, voluntary experimentation

which some medical researchers might perform upon themselves in order to try to develop a cure).

Accordingly, from the standpoint of the social consequences of transmitting the virus, a case can be made for *mandatory* testing. Ignorance normally exonerates. *Willful* ignorance, as Aristotle argued, does not. One cannot morally refuse to know whether or not one carries the disease when transmission can result in serious injury or death.

The last point brings us to a volatile issue in the public debate, one which is fraught with paranoia and misunderstanding. It is an unfortunate fact that, in this country at least, "high-risk" populations for AIDS are also outcast populations socially. The fact that the disease has now spread beyond homosexual and drug-abuse populations has done little to stop paranoia on the part of these groups, and has probably exacerbated the problems of their outcast status. Yet the paronoia of these specific populations, however justifiable, must not be allowed to cloud the issue of what measures are necessary to stop a possible epidemic. There is no right to spread lethal disease. There are, however, sound grounds for arguing that "high risk" groups ought not to be singled out for special measures, such as mandatory testing.

Internationally, the disease is not at all confined to these populations, nor can it be proven to have originated in them. Evidence suggests that it is no longer confined to these groups in this country.[7] Since it is not exclusively a disease "belonging" to these groups, there is no ground for isolating these groups for testing. At what point the demographics of the disease will force the issue of universal, mandatory testing is difficult to say,[8] but its justifiability, in theory, is not.

It is, of course, the case that testing is itself fraught with difficulties, such as the long incubation period for the disease and questions concerning the very reliability of the present tests, including the problems associated with false positives. These complex empirical problems make it very difficult to determine precisely at what point the presumption for individual freedom might be justly abrogated. Yet these difficulties, however great, ought not to be taken as arguments against universal, mandatory testing. It could be argued, for example, that the threat of such testing would merely drive people, particularly those in high-risk categories, "underground." This could no doubt happen. But it is also highly probable that *universal* testing would lessen the reticence of "high risk" groups to be tested, since it could not be considered discriminatory.

The Issue of Quarantine/Isolation

What ought to happen if one is found to test positive? While AIDS is, of course, an illness, its *primary* means of transmission, at this point, appears to be sexual. This renders the issue of quarantine/isolation extremely problematic. It is rendered more problematic by empirical confusion, even among experts, *concerning* the possibilities of the disease's transmission

by other "involuntary" means — e.g., by salvia, mosquitoes, etc., and not simply by transfusion or by other contact with infected blood or semen.[9]

Even if we were to focus only on transmission by sexual means, however, the issues of quarantine and/or isolation would not thereby be done away with. Even if the infected person was an "innocent" recipient of the disease, e.g., a hemophiliac, we would still be justified in considering the objective danger of spreading the disease more important than the loss of freedom which might ensue, even to an "innocently" infected person. Can we depend upon voluntary abstinence or upon voluntary use of condoms? May we presume that a carrier is honest in telling sex partners he/she is infected? Here we have a "human nature" assumption of the first magnitude at work. Even those claiming fidelity for five years or longer[10] have been known to fool or to be fooled, have they not? Everyone today is at some risk.

For the above reasons, the claim of some infected sufferers to have a *handicapping condition* analogous, say, to being confined to a wheelchair for non-contagious reasons, is dubious in the extreme.[11] And, if there should prove to be other means of transmission than the (primarily) sexual, the argument for isolation will become very compelling. In the light of "human nature" and empirical uncertainty, prophylactic measures can be defended, including segregation in hospitals.

Financial Responsibilities

Insurance executives have claimed that the life-style of persons presently in high-risk groups for AIDS, produces risks analogous to those produced by cigarette smoking: if claims can be adjusted or refunded for this, why not for AIDS?[12] This problem raises questions not only of a financial, but also of a deep philosophical nature. They are not irrelevant questions for hospitals, of course.

Insurance industries agree that adults are responsible for their behavior, especially for their sexual behavior! They also tend to argue that certain forms of sexual activity constitute high risk behavior; hence they feel justified in selectively screening these applicants for insurance. The argument, on the face of it, is a strong one. It is difficult to ascertain what arguments justify compelling private companies to pay for the illnesses of persons who persist in high risk behavior.

The case for government intervention is a more subtle one. One could argue that government has a responsibility to pay for *accidental* diseases and events befalling innocent persons, but the sexual and drug-abuse modes of transmission for this disease may cause it to fall into a "borderline" area.[13] It is also the case that the "cost-benefits" analysis which large governmental agencies tend to follow will often favor prevention over cure or treatment. That is to say, in the case of AIDS tax dollars would most probably be maximized by screening (testing) and by instituting various methods of stopping the transmission of the disease

than by treating those already affected. Such is the type of reasoning that causes some to question the enormous expense of AZT in the treatment of apparently hopeless cases.

At any rate, failure of private or governmental agencies to pay for these unfortunate sufferers poses urgent dilemmas for hospitals, particularly for those claiming allegiance to religious values. The care for persons irrespective of causes and costs is often a religious ideal. But it is also obvious that hospitals might not be able to carry this burden alone. Hospitals may have to pool resources in order to deal with the problem of AIDS, while at the same time lobbying government for greater financial support. Such pooling may include, for example, the building of sanitariums in key geographical areas.

Responsibilities of Administrators of a Christian Hospital

The public debate concerning the personal responsibility of the sufferer may inevitably prove to be a difficult, but necessary, moral issue for a hospital to discuss. Obviously, hospitals provide care to the sick, regardless of etiological or causal questions concerning the illness or injury. This is even more the case for an institution grounded in religious values, such as grace, forgiveness, unconditional love, etc. (It will not be argued here why these theological ideas may coincide with determinism and thus weaken arguments concerning the *culpability* of sufferers).

Thus, with regard to a religious hospital's moral obligation to the indigent in general, and to some AIDS sufferers in particular, a religious institution may not recognize the obligation/supererogation distinction that a more secular hospital might prefer. The case for the outcast, regardless of cause, is, in light of the Bible a moral obligation, and not a non-required but nice thing to do.

Thus, *prima facie,* a religious institution's unconditional obligation to the sick could be seen to run counter to some aforementioned views concerning patient/sufferer responsibility. And, in the extreme, an attitude of unconditional caring such as this could financially destabilize, and ultimately destroy a hospital, particularly if these measures are not concerted with or shared with other hospitals and caring institutions.

The problem is that institutions have responsibilities to their constituents to *survive* — certainly not at *any* moral cost, but perhaps at a *great deal* of cost. In addition to the obvious burden of direct financial costs raised by AIDS, there are public relations costs as well. Lawyers for fired AIDS employees have argued that hospitals are only interested in what the public will think.[14] This argument has some truth to it, but is reductionistic in the extreme. It is not unusual or immoral for an institution to delicately balance its public relations with the issues of employee or patient "rights." While it is true that the public suffers from a great deal of misinformation concerning AIDS, especially concerning its transmission, there is even conflicting information among experts. And

although truth and education are obviously parts of what any hospital stands for, the hospital's position, in light of empirical uncertainty, is very problematic.

If there is absolutely *no* danger of ("accidental") transmission of AIDS, then there is *real discrimination* if infected employees are fired or reassigned. Few experts, however, would argue that *there is absolutely* no danger of such transmission.[15] Given this *slight empirical possibility* of harm, intentional or not, it follows from what has been argued previously, that mandatory testing of employees and patients is warranted, and perhaps segregation and/or dismissal as well. An extreme prophylaxis, until some coherence can be brought to the empirical dimensions of this problem, is good for the society and "good PR", both in a moral and in an effective sense.

An institution, by its very nature, must be utilitarian in character. It must coolly weight the facts, including financial costs and public relations, in the balances with issues such as the "rights" of patients and employees. If the hospital were empirically convinced that an employee or patient infected with the virus posed no threat to the health of others, it would still have to weigh this truth in the balances with the costs of public reaction. This is utilitarianism's "Achilles heel" — that it justifies itself in hanging an innocent man in order to stop a riot.[16]

The situation becomes ever murkier with threats of expensive lawsuits by "handicapped" employees. That is why a hospital has a responsibility to educate the public concerning the logical difference between a handicap and a CONTAGIOUS disease.

One final comment for hospital management. It is not beyond possibility that there might come a time when care for AIDS patients becomes so financially prohibitive that the resultant competition for scarce resources may make the issue of personal responsibility a selection factor for an otherwise unconditionally caring institution. Those familiar with the "lifeboat ethics" game will remember that culpability is often selected as a criterion for allocation or non-allocation of scarce resources. It is therefore not inconceivable that, should this disease become a massive epidemic, a philosophical conflict between the ideas of personal responsibility and unconditional caring will be forced. It will not be pretty or easy. And though it is too "abstract" for many, its "resolution" will be a logical necessity before any clarity can be given to the question of what "ought" to be done.

Employee Obligations: Doctor-Patient Confidentiality

The literature on AIDS shows a growing emphasis on confidentiality in the doctor-patient relationship. *Voluntary* tests and counseling are advocated by almost all relevant institutions but the insurance agencies.[17]

There is a great problem here. Historically, the doctor-patient relationship has been built, of course, on trust and confidentiality. These

values, and their underlying abstract norms of truth-telling and promise-keeping have often been used to counter utilitarian claims to *use* the one or the few for the sake of the many. In most cases, the idea that the physician is *directly* or *primarily* responsible to the patient, and only secondarily responsible to the society or to scientific advancement, is a laudable one, and one with great presence in historic codes of medical ethics.[18] It is also the case that a disclosure of a patient's disease status often brings social stigmatization and loss of financial security. For these reasons, ethicists have written to the effect that the *labeling* of the sick is justified only to the extent that such labels conduce to access, by the sufferer, to special resources and privileges.[19]

These historic principles are good presumptions but do not apply completely to AIDS. AIDS is an illness involving *triadic* relationships: the physician, patient and *others* are involved (e.g., sex partners and, perhaps various financial institutions). There has been a history of government and hospital-supported contact-tracing with regard to other venereal diseases, and AIDS ought not to be an exception.[20]

Consequentialist moral arguments (i.e., those arguments of a non-religious nature)[21] usually conclude that the important norms of promise-keeping and truth-telling, which underlie not only medical relationships, but the very ability of societies to function at all are, while stringent, not nearly as stringent as the norm to avoid the injury/death of other persons. Only a deontological fanatic[22] could think that confidentiality is more important, in conflict-of-rule situations, than avoiding harm.

The fact that confidentiality has been abrogated in other cases regarding sexually transmitted diseases attests to the tremendous political lobbying power of groups presently afflicted, and not to the moral legitimacy of such an attitude vis-à-vis the social contact.

Disclosure by Employees?

According to one professor of health law, the obligation of employees to disclose disease-carrying status would be binding if there were possible harm of transmission.[23] Here, truth-telling would be in tandem with non-maleficence (not harming). A patient's right to *informed consent* of this kind is only valid where the possibility of harm is established. Empirically, transmission through medical care and surgery is a very difficult problem. It would be better to err on the side of disclosure than to run the risk, however small, not only of transmission of infection, but also of what one lawyer projects as litigated damages in the tens of millions of dollars, should a patient receive the disease from a hospital employee.[24]

Mandatory testing of employees and patients would, of course, disclose an employee's or a patient's illness to at least certain members of hospital management. Management would, in the case of the infected employee or patient, have to decide among various options: to do nothing and hope for the best; to dismiss or isolate the employee or patient; or perhaps to allow

the patient or employee to continue their relationships, provided that the infected party disclose his or her status to the other, and that the non-infected party consent.

Again, management is forced into the position of having to prioritize various harms. It should keep in mind, however, that the presumption "do no harm" is most stringent in the form of causing death. The harms of stigma and joblessness, while obviously grievous, are not as important as not killing. (See addendum).

The recent decision of the Center for Disease Control to oppose mandatory tests, while at the same time endorsing contact tracing, shows the paradoxes resultant from failing to weight the norms correctly.[25]

A Problem for the Medical Researcher

One other position of the CDC seems morally indefensible on the basis of the admittedly sketchy ethical framework proposed. This is the problem of the *anonymous* testing of blood samples (as opposed to *confidential* testing). A researcher involved in the study contended that it would have been unethical to test "identified" blood samples without permission. Here informed consent is said to outweigh what one researcher called "the only downside" to the experiment — that patients would not know they were positive.[26]

This type of non-consequential reasoning, which implies that anonymity is more important than the spread of death, is certainly difficult to defend. Consequentialists argue that we are responsible for sins of *omission* as well as for sins of commission.[27] In this respect the researchers could be found *morally* guilty of complicity in homicide.

It is thus an interesting question (one occurring often with regard to experimental designs using placebos) whether or not the above-mentioned statistical experiment amounts to *withholding known effective treatment* (if drugs like AZT can be considered at all efficacious).[28]

Ought an Employee be Forced to Work with AIDS Sufferers?

Self-sacrifice is, from a religious perspective, of the highest moral order. "Secular" societies also give lip-service to it. Only in extreme situations can it be considered *obligatory* to sacrifice oneself for another. It must, according to social contact theory, be supererogatory and therefore purely voluntary. The only exception is, possibly, wartime, when the perceived threat to the body politic is so grave that the flower of the nation's youth can be involuntarily conscripted and can possibly face death as a result. It is hard to see a physician's role vis-à-vis an AIDS patient as at all analogous to a wartime situation. Even a *massive* epidemic would not be analogous, since, at present, AIDS is a thoroughly lethal disease. No one can *require* self-sacrifice for hopeless cases.

Heroes and saints are admired by secularists and religionists alike for running self-sacrificial risks. But no one can make this mandatory or

obligatory. There would be no social contract if individuals were forced to take these risks. The self-preservation of the individual is the reason for the contract in the first place.

Since the Hippocratic oath, physicians have been seen to *verge* on making the supererogatory the obligatory.[29] But this must be a religious (or quasi-religious) decision of the physician, one made without coercion. One could argue that the highest *religious* value is self-sacrifice, but not even a religious hospital could turn this into an obligation.[30] Still, it may be the case that a society that does not try to *instill* the moral values of risk and self-sacrifice for the sake of others will not, in the end, be able even to function at all.

Summary

AIDS may come to constitute a national emergency, in terms of lives and dollars, of such magnitude that the normal presumptions for maximal individual freedom can justly be abrogated. In light of both important empirical certainties and uncertainties concerning its transmission, universal mandatory tests and even subsequent isolation can be defended as measures morally undertaken both by the state and by other relevant institutions, such as hospitals.

Though issues of individual responsibility and culpability may necessarily arise, particularly from a "secular" social-contract perspective, a religious hospital, and individual religious employees bear a terrible responsibility for these unfortunates. What happens to them, and who will pay for them, is a problem that the religious conscience cannot shirk as easily as the secular.

References

1. Chisolm, R., "Supererogation and Offense: A Conceptual Scheme for Ethics", *Ratio*, Volume 5, June, 1963, pp. 1-14.

2. In what follows, I am presupposing the argument of Hans Jonas, "Philosophical Reflections on Experimenting with Human Subjects", in S. J. Reiser, A. J. Dyck and W. J. Curran, eds., *Ethics in Medicine: Historical Perspectives and Contemporary Concerns*, Cambridge, Massachusetts, MIT Press, 1979, pp. 304-316. His application of the "Social Contract" theme to problems of medical ethics distinguishes a predominantly secular understanding of obligations based on enlightened self-interest from the self-sacrificial theme of much religious morality. I utilize the "Social Contract" theme not on the basis of the validity of any specific version of it, but simply because it offers a plausible framework for understanding the moral obligations of citizens independent of specific religious beliefs. I use the term "natural law" in a similar sense: see O. Gierke, *Natural Law and the Theory of Society*, translated by E. Barker, Boston, Massachusetts, Beacon Press, 1960. Not all voluntarily chosen values that go beyond the social contract are religious, of course. I use this bifurcation only because of its applicability to the problems of a Christian hospital.

3. See, e.g., Dorothy Emmet, *Rules, Roles and Relations* (Boston, Massachusetts: Beacon Press, 1966).

4. John Rawls, *A Theory of Justice* (Cambridge, Massachusetts: Harvard University Press, 1972).

5. See, e.g., C. B. Chapman and J. M. Talmadge, "The Evolution of the Right to Health Concept in the United States, in *Ethics in Medicine,* op. cit., pp. 553-572.

6. H. L. A. Hart, "Laws and Morals", in *Ethics and Medicine,* op. cit., pp. 104-114.

7. "Surgeon General's Report on Acquired Immune Deficiency Syndrome", U. S. Department of Health and Human Services, 1987.

8. I find no evidence, in relevant literature, of a statistical point at which such measures could be mandated. It will probably come as a result of the recommendation of a consensus among experts at relevant institutions.

9. See, e.g., J. Seligmann and M. Hager, "A New Worry for Health-Care Workers", *Newsweek,* June 1, 1987, p. 55; see also n. 11, p. 349.

10. This is the figure given in the Surgeon General's Report, *op. cit.,* n. 7.

11. See G. Matthews and V. Neslund, "The Initial Impact of AIDS on Public Health Law in the United States", *Journal of the American Medical Association,* Vol. 257, no. 3, pp. 344-352.

12. Chase, M., "How Insurers Succeed in Limiting Their Losses Related to the Disease", *Wall Street Journal,* May 18, 1987.

13. See, e.g., Gene Outka, "Social Justice and Equal Access to Health Care", in *Ethics in Medicine,* op. cit., pp. 584-593.

14. Meyer, H., "AIDS Job Bias Growing Fast in Health Industry", *American Medical News,* Feb. 27, 1987, p. 34.

15. Scher, R., "As More MD's Develop AIDS, Ethical Issues Come to Surface", *American Medical News,* March 13, 1987, p. 35.

16. See J. J. C. Smart and Bernard Williams, *Utilitarianism: For and Against,* (Cambridge, England: Cambridge University Press, 1973).

17. Chase, M., "Asking AIDS Victims to Name Past Partners Stirs Debate on Privacy", *The Wall Street Journal,* Jan. 29, 1987, p. 1.

18. See, e.g., "The Nuremberg Code", in *Ethics in Medicine,* op. cit., pp. 272-274 and World Medical Association, "Declaration of Helsinki", pp. 328-330.

19. Potter, R. B., "Labeling the Mentally Retarded: The Just Allocation of Therapy", in *Ethics in Medicine,* op. cit., pp. 626-631.

20. *Op cit.,* n. 11.

21. There are, of course, consequentialist arguments that do rest upon religious presuppositions. However, I have in mind here the type of deontological reasoning that makes normative judgements according to the "will of God" independent of consequences.

22. E.g., the assertion by Immanuel Kant that it would be wrong to lie in order to save an innocent man from death, "On an Alleged Right to Life from Altruistic Motives," translated by A. E. Kroeger in the *American Journal of Speculative Philosophy,* Vol. VII, 1873.

23. Scher, *op. cit.,* n. 15.

24. Scher, *op cit.,* n. 15.

25. "Wider AIDS Virus Testing Urged", *American Medical News,* March 13, 1987, p. 9.

26. *Ibid.,* p. 9.

27. E.g., Peter Singer, *Practical Ethics,* (Cambridge, England: Cambridge University Press, 1981).

28. On this problem, see S. Bok, "The Ethics of Giving Placebos", in *Ethics in Medicine, op. cit.,* pp. 248-253.

29. See W. F. May, "Code and Covenant or Philanthropy and Contract", in *Ethics in Medicine, op. cit.,* pp. 65-77.

30. It could be argued that while a religious hospital could not turn the (potential) act of self-sacrifice into a legal or quasi-legal obligation, it could promote it as a *moral* obligation binding on Christians or Jews.