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Supererogatory Duties and Caregiver Heroic Testimony

Chris Weigel

Abstract

The sacrifices of nurses in hard-hit cities during the early stages of the COVID-19 pandemic and of family caregivers for people with late-stage Alzheimer's disease present two puzzles. First, traditional accounts of supererogation cannot allow for the possibility of making enormous sacrifices that make one's actions supererogatory simply to do what morality requires. These caregivers, however, are doing their moral duty, yet their actions also seem to be paradigmatic cases of supererogation. I argue that Dale Dorsey's new account of supererogation can solve this puzzle. Second, these caregivers often deny that they are heroic, but standard explanations of these assertions either diminish their sacrifice, say they are confused, or attribute to them a vice. If we want to understand them without diminishing them, we should instead see their denials as a response to what Beth DeVolder calls compulsory heroism. Compulsory heroism occurs when someone is foisted into the role of hero for doing their moral duty as a distraction from the social realities that make doing their duty involve inordinate sacrifice.

Keywords: nursing, family caregiving, supererogation, Dale Dorsey, compulsory heroism, heroic testimony

To say that caregivers such as nurses and family members of people with Alzheimer's disease do their moral duty is relatively uncontroversial: to refuse to give care would be an abdication of one's moral responsibility. Also uncontroversial is the claim that often they make extraordinary sacrifices, going far beyond what many other people do, incurring strenuous hardships, in a way that makes them paradigmatic cases of supererogation. Nurses in hard hit cities during the early stages of the COVID-19 pandemic and family caregivers of people with late-stage Alzheimer's disease are particularly relevant here.[1] Standard accounts of supererogation can't

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[1] For brevity, I will sometimes call the latter caregiving "family caregiving." Again, only for the sake of brevity, when I want to talk about nurses and family caregivers together (or only nurses and family caregivers), I will sometimes use the terms "caregivers" and "caregiving." This should not be taken to imply that both categories

account for these caregivers because what they do straddles the divide between what is and what is not supererogatory.[2] On the one hand, they are doing their duty, so they are not performing supererogatory actions. On the other hand, their enormous sacrifice, being particularly meritorious, suggests that they are doing something supererogatory. This is the first puzzle about supererogation that I examine. I argue that Dale Dorsey's (2013, 2016) new account of supererogation can explain this kind of caregiving. Dorsey's view says that rather than holding as a condition for supererogation that the act be especially meritorious compared to one's *moral* duties, the act instead needs to be especially meritorious compared to one's *all-things-considered* duties. All-things-considered duties include, but are not limited to, moral, prudential, and legal duties. As a result, one's actions can be supererogatory and still be one's moral duty. The caregiving I discuss is relatively common, and since traditional accounts can't satisfactorily explain it while Dorsey's view can, this is a novel argument for Dorsey's view.[3]

These caregivers present a second puzzle, this time about what is called *heroic testimony*, the phenomenon of denying that one is a hero when called a hero. Their heroism can best be seen as involving enormous sacrifices while doing one's moral duty as the result of ongoing and systemic problems.[4] People often hail caregivers as

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are basically the same: nurses are highly trained medical professionals, for example, and family caregivers are usually unpaid.

[2] I owe thanks to Cynthia Stark for the idea to frame the paper this way. Additionally, I owe thanks to an anonymous reviewer for helping me separate and clarify the two puzzles.

[3] Dorsey's account is controversial; I do not claim to discharge other critiques of Dorsey's view. Archer (2015), for example, argues that the point of an account of supererogation is (1) to explain why it would be inappropriate to demand that the soldier throw himself on the grenade, (2) to explain why the soldier would not be blameworthy if he did not throw himself on the grenade, and (3) to do justice to the everyday notion of going above and beyond the call of duty. Archer argues, moreover, that Dorsey's account cannot accomplish these tasks.

[4] Arguably, not all heroic acts involve large sacrifice, such as rescuing a drowning person when one is an excellent swimmer and trained lifeguard. Moreover, not all heroic acts involve systemic and ongoing issues, as the previous example also shows. For the purposes of this paper, however, "heroic" will refer to certain acts that involve enormous sacrifices while doing one's moral duty as the result of ongoing and systemic problems. (We shall see that the standard account of supererogation would say that these actions cannot be supererogatory because they are moral duties, but that Dorsey's account can say they are supererogatory.) I owe thanks to an anonymous reviewer for pointing out that my analysis doesn't give a unified account

heroes, but then the caregivers resist being called heroes. Why would they do so, even while keenly experiencing the sacrifice? Standard accounts of heroic testimony either diminish their sacrifice, say they are confused, or attribute to them a vice. I argue that seeing heroic testimony instead as a resistance to compulsory heroism is superior. According to Beth DeVolder's (2013) account, *compulsory heroism* is the phenomenon wherein someone is foisted into the role of hero for doing their moral duty as a distraction from the social realities that make doing their duty involve inordinate sacrifice. I argue that it is better to see claims like "I'm not a hero" as a way of rejecting the compulsion in the caregiving rather than as false modesty, confusion, or as correct because the sacrifices aren't enormous.

An examination of caregiving, thus, sheds light on both the nature of supererogation and on how to interpret heroic testimony. To show how, in section 1, I discuss the social realities involved in these two kinds of caregiving. In section 2, I explain the puzzle about the nature of supererogation, showing how the traditional account cannot make sense of caregiving. In section 3, I show how Dorsey's account of supererogation can make sense of caregiving by allowing for supererogatory actions that are also one's moral duty. Section 4 gives concrete examples of heroic testimony on the part of caregivers and explains the second puzzle, which is that standard interpretations of heroic testimony either say caregivers are confused, diminish their sacrifice, or attribute to them the vice of false modesty, all of which are problematic. Section 5 provides a solution by allowing for another interpretation. I explain DeVolder's idea of compulsory heroism and apply it to caregiving, showing how caregiver heroic testimony can be seen in the light of resistance to compulsory heroism. Seeing heroic testimony in this light provides a superior account. Section five concludes by briefly showing how the solutions to the two puzzles are complimentary.

1. Social Realities of Some Extraordinary Caregiving

Recall that my argument begins with two relatively uncontroversial claims: often, caregivers are doing their moral duty, and they are also making sacrifices so extreme that they look like paradigmatic cases of supererogation. These claims can be made more vivid by briefly examining the social realities of my two cases in more detail.

1A. Pandemic Nursing

During the COVID-19 pandemic, in less than a year (as of late October 2020), 1,500 nurses' deaths were recorded globally (Wright et al. 2020). There are approximately four million nurses in the United States (Schnur 2020). As of 2017, 19.2

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of all heroic testimony: the ongoing and systemic nature is what makes my analysis work.

percent are minorities and 91 percent are female (National Nursing Workforce Study 2020). Some hospitals have required nurses to work even when sick with COVID (Clark 2020). Many nurses have not had access to COVID testing while athletes and actors received daily testing (Wright et al. 2020). They have been tasked with caring for more patients than is safe and have been asked to do work for which they have not been trained or that falls outside their specialty (Wright et al. 2020), exacerbating the already present vulnerability to moral distress (see, e.g., Jameton 1984; Campbell, Ulrich, and Grady, 2016). Caitrìona Cox (2020, 511) enumerates some ways in which, during the pandemic, "the risks to healthcare workers are appreciably greater than those encountered in normal practice." Nurses often must live away from home to avoid placing family members' health at risk; they are at heightened risk for becoming ill from COVID themselves, and at heightened risk for dying, particularly when personal protective equipment is lacking. And of course, moral distress, emotional distress, and physical exhaustion are all heightened (Cox 2020, 511). Their voices have been largely left out of the decision making that affects them (Wright et al. 2020). They have taken on these risks knowing that large numbers of people refused to wear masks or social distance and that many politicians did not enact policies that would stem the crush on hospitals.

1B. Family Caregivers for People with Late-Stage Alzheimer's Disease

With the nursing example in mind, turn to another example, widespread enough to be a "pandemic" in another of that word's senses. This is the case of caregiving as a family member for people with Alzheimer's disease.[5] In 2015, nearly one in twenty Americans were family caregivers for people with Alzheimer's disease (Family Caregiver Alliance 2016). As the population ages, the percent of people who provide caregiving will increase. Caregivers do experience joy and fulfillment, but the research on caregivers also portrays grave vulnerabilities: financial, emotional, and physical. Family caregivers face a myriad of risks, some obvious and some less well known. They include anxiety and depression (Mahoney et al. 2005), social isolation (Brodaty and Hadzi-Pavlovic 1990), lowered quality of life (Thomas et al. 2006), diminished immune response to vaccines (Mills et al. 2004), disrupted sleep (Cupidi et al. 2012), missed doctor's appointments of their own (Healthline 2018), a greater risk of developing Alzheimer's disease than non-caregivers (Norton et al. 2010), and moral distress (Weigel 2019). Another part of the issue is that family caregiving often involves advanced skills, but little training is given (Washington 2021, 29). And the

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[5] Family caregiving for people with Alzheimer's disease was chosen to simplify the narrative. Family caregiving for people with any type of dementia and for people with any type of critical illness are relevantly similar, and presumably other kinds of caregiving would be too.

work disproportionately falls on women, most of whom have children (whose care falls disproportionately on them as well).

With these cases delineated, we can now examine a puzzle about supererogation that arises from these caregivers' actions.

2. Puzzle One: The Nature of Supererogation

J. O. Urmson's seminal essay "Saints and Heroes" argues that any moral theory that does not account for supererogation is "inadequate" (Urmson 1958, 199). He describes the supererogatory as "going the second mile" and "going beyond duty" (202). For Urmson, supererogatory actions are not mere duties, nor are they acts that are permissible but not required, nor are they wrong; they form a fourth, independent category of moral conduct that we need in order to capture what saints and heroes do.

Since the publication of Urmson's essay, attempts to understand supererogation have proliferated. Alfred Archer (2018, 5) notes of this literature that "there is wide agreement that acts of supererogation are both morally optional and morally better than the minimum that morality demands.". A supererogatory act must be morally optional, for if it is morally required, then it is a duty. Moreover, because "supererogatory" is a comparative term, supererogatory acts must be better than the minimum demanded by morality. Yet these two criteria, while necessary, are not sufficient for an act to be supererogatory. The following example shows why: it is morally optional to compliment a friend's jacket, and the minimum that morality demands is to not say anything unkind. So, the compliment is morally optional and morally better than saying nothing. However, intuitively, it isn't supererogatory. This suggests that for an act to be supererogatory, it must be morally optional and *particularly* morally good compared to other morally permissible options (Dorsey 2016, 120). Furthermore, some supererogatory acts, though optional, would be morally required were it not for the fact that they demand a significant sacrifice from the person who performs them (Dorsey 2016, 120).

Dorsey captures this *traditional account of supererogation* with these conditions:

> [1.] *Permissible[,] Not Required*: If an act ϕ is supererogatory, ϕ is morally permissible, but is not morally required.
> . . .
> [2.] *Morally Good:* If an act ϕ is supererogatory, ϕ is *especially* morally good or meritorious in comparison to other morally permissible actions. (Dorsey 2016, 109–10)

A subset of supererogatory actions additionally fills this condition:

> [3.] *But for Sacrifice*: A subset (*S*) of supererogatory actions would have been morally required but for the fact that they require non-trivial sacrifice on the part of the agent. (Dorsey 2016, 110)

My claim is that the traditional account cannot properly make sense of caregiving. If it characterizes caregivers' actions as supererogatory, then according to condition one, they are not doing their moral duty. But intuitively they are: for nurses, it is their job, and for family caregivers, it is a standard obligation to care for ill family members. On the other hand, if the traditional account characterizes their actions as duties, then it cannot explain the fact that these cases otherwise seem like paradigmatic instances of supererogation. The traditional account says that doing what morality requires and doing something supererogatory are mutually exclusive: it does not allow for the possibility of supererogatory actions that involve simply doing what is morally required.[6] The traditional account hence does not allow for the possibility that ongoing and systemic failures can make doing one's duty supererogatory, which we would like to be able to say is what is happening with these caregivers. An account of supererogation that would allow for the possibility of supererogatory duties would thus be superior in that it would allow us to get at the phenomenon on display with these caregivers. To that account we now turn.

3. Puzzle One Solution: Dorsey's Account of Supererogation

The traditional account of supererogation outlined above invokes three types of moral act: those that are permissible *tout court*, those that are required, and those that are permissible but would be required if they did not demand excessive personal sacrifice. Morality, however, is not the only domain of normativity, as Dorsey points out. There are several others. For instance, there are prudentially required or permitted acts,[7] legally required or permitted acts, acts required or permitted by etiquette, and acts required or permitted in virtue of one's role or membership in a group, such as a neighborhood association (Dorsey 2013, 369). When our normative requirements conflict, what we ought to do, according to Dorsey (2013, 369), is our all-things-considered requirement. Dorsey dubs the all-things-considered requirement the "rational requirement," and I will keep this terminology. Rational requirements, then, are requirements that take into account not only moral

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[6] Thanks are owed to an anonymous reviewer for helping me make this point clear.

[7] I understand prudence as Benn and Bales (2020, 918) do, where "prudence relates to how we ought to act so as to promote our own well-being."

considerations but also legal, prudential, and other considerations. His *new account of supererogation* makes use of the notion of rationally required/permitted actions:

> [1.] *Permissible[,] Not Required II*: If an act ϕ is supererogatory, ϕ is rationally permissible, but is not rationally required.
>
> . . .
>
> [2.] *Morally Good II*: If an act ϕ is supererogatory, ϕ is *especially* morally good or meritorious in comparison to other rationally permissible actions. (Dorsey 2016, 127)

A subset of supererogatory actions additionally fills this condition:

> [3.] *But for Sacrifice II*: A subset (*S*) of supererogatory actions would have been rationally required but for the fact that they require non-trivial sacrifice on the part of the agent. (Dorsey 2016, 127)

To illustrate his account, Dorsey gives the example of Rose. Rose has enough money that she is in a position where she is morally required to help others with it, but helping others would be burdensome to her. Alternatively, she can "live the life she would otherwise want to" (2013, 370). Dorsey says that although helping others is a moral requirement, "Rose is not rationally required to do so" (370). So, Rose has moral requirements that are not rational requirements: "Rose's action is morally required in a way that isn't *required of her"* (370; emphasis in original). If Rose does decide to help others, she has done something that is both morally required and supererogatory under the modified definition of supererogation. In other words, this definition of supererogation allows for the possibility that supererogatory acts can be morally required. They are a moral duty while they are also above and beyond the call of rational duty: our moral duties do not exhaust the set of our duties.

Here is how Dorsey's account of supererogation can make sense of these cases of caregiving. First, consider nurses during the COVID-19 pandemic who work without adequate staffing or personal protective equipment. Working in these circumstances meets the *permissible, not required II* condition of Dorsey's view. To work in these circumstances is rationally permitted. Recall that to be rationally permitted, on this understanding, is to be permitted, all things considered. Nurses have all sorts of obligations, including moral and prudential. It is rationally permitted to weight the moral considerations so strongly that they supersede the prudential considerations. Yet it isn't all-things-considered required (i.e., it isn't rationally required) to work in these circumstances. Nurses are not required to give precedence to moral considerations when the prudential costs are so extremely high.

Working in these circumstances also meets the *morally good II* condition in Dorsey's account, for continuing to work is morally better than the rationally permissible option of not continuing to work. Refusing to work without adequate staffing and without personal protective equipment involves weighting prudential over moral considerations. Such a weighting is one way the all-things-considered reasoning could go. Working and not working are both rationally permissible, but working is morally better than the rationally permissible option of not working. Because working meets both these conditions, nurses' actions are supererogatory on the modified view even though they are morally required. The modified view, therefore, shows how it is consistent to say that nurses are doing their moral duty and that the enormous cost they incur means that their actions are still supererogatory.

So, too, for family caregivers. What they do is rationally permissible, but not rationally required, meeting the *permissible, not required II* condition of the modified view. If taking on the type of caregiving that requires you to put your life on hold, and makes you vulnerable financially, socially, emotionally, and physically, is rationally required, it would have to be a requirement of all-things-considered rationality, which includes considerations of prudence, among others. Since it may not be prudent (and hence not rational in this sense) for the family caregiver when considering their life as a whole, this type of family caregiving is not rationally required. Such family caregiving is rationally permitted, though, since it is rationally permissible to give precedence to moral considerations over prudential considerations. Second, family caregiving meets *morally good II* as explicated by Dorsey: it is especially morally good in comparison to other rationally permissible actions. For example, for someone who has a full-time paid job and small children, it would be rationally permissible to let a slightly less capable sibling who does not have a paid job or other substantial obligations do the care work. Here too, we can say that family caregivers are doing supererogatory actions that are also their moral duty.

Dorsey (2016, 131–36) defends his account by saying that it avoids certain counterintuitive implications about moral justification and the moral point of view. For those not satisfied by Dorsey's arguments about moral justification and the moral point of view, however, the considerations raised by nurses and family caregivers generate additional and novel support for the new account for supererogation. If we want to hold the intuitively plausible view that caregivers are both fulfilling their moral duties and performing supererogatory actions in so doing, we need Dorsey's account. Another way of putting the point is this: only Dorsey's account of supererogation can explain the (arguably uncontroversial) notions that caregiving can be both morally required and involve the kind of sacrifice that typically makes an action supererogatory. The fact that the account can explain not only hypothetical, abstract cases from thought experiments but also the lived experiences of a myriad of caregivers is an important strength.

To assert that Dorsey's account of supererogation explains the fact that caregiving is a supererogatory moral duty, however, is not to undermine the social problem where people are expected and expect themselves to make grave sacrifices to do what is morally required of them. The social problem often manifests itself in heroic testimony. Caregivers often experience a tension about being called heroic while doing their moral duty. Prior accounts of heroic testimony fall short of explaining caregiver heroic testimony, which is another puzzle that the case of caregiving presents.

4. Puzzle Two: Heroic Testimony

The second puzzle about caregivers, then, involves the interpretation of heroic testimony. To explain the puzzle, I will revisit nurses and family caregivers to show what heroic testimony looks like in these concrete cases. Recall that I am using the term "heroic" in a specialized sense: heroic acts involve enormous sacrifice while doing one's moral duty because of systemic and ongoing issues.

4A. Pandemic Nursing

It should come as no surprise that nurses have been hailed as heroes in the media frequently during the early stages of the COVID-19 pandemic.[8] Many nurses, however, resist being called heroes. A myriad of reasons has been offered. Some of the reasons mentioned by others follow, but this list does not purport to be complete:

1. Calling someone a hero at the same time you treat them as a commodity is exploitative (Wright et al. 2020).
2. "The 'hero' rhetoric distracts from the forces that are really responsible for their plight: government negligence, inequality, and a health care system driven by profit" (Wallis 2020).
3. "Calling [someone] a hero empowers you to tell [them] that's enough because that's the highest compliment you can give [them]. I don't need a compliment; I need safe staffing" (Wallis 2020).
4. "A public narrative that concentrates on individual heroism fundamentally fails to acknowledge the importance of reciprocity. . . . There must be recognition of the responsibilities of healthcare institutions and the general public" (Cox 2020, 512).

The resistance to being called a hero often takes the form of saying "I was only doing my duty" or "I did nothing special: I just did what I had to do." These nurses,

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[8] Representative samples include Dohrenwend (2020), Sidman (2020), Brusie (2020), and Marcus (2020).

hence, are giving heroic testimony, which, as noted above, is the phenomenon of claiming that one's action is not, contrary to someone else's claim, heroic. As one nurse puts it, "Even when the world is in flames, I just still wanna do the right thing and bring joy and love to people. I don't want to be called a hero. I am simply a woman—an African American woman who just wants to see people survive now" (Wallis 2020). This nurse disavows the hero label, characterizing herself instead as someone who is performing the duties of a nurse.

4B. Family Caregivers

Family caregivers, too, are hailed as heroes. In "Families as Caregivers: The Limits of Morality," Daniel Callahan calls family caregiving heroic because of "those features that seem to pose a direct and fundamental threat to the welfare and happiness of the person who gives the care" (1991, 159)—namely, proclivities toward anger, guilt, lack of self-worth, social isolation, stigma, and "a future that promises no relief" (160–62). This leads him to raise questions about what he calls "the limits of obligation," claiming ultimately that "heroic self-sacrifice . . . is only possible if understood within the context of an entire way of life, and a way of life set ultimately within some scheme of religious or higher meaning" (Callahan 1991, 167). That is, "morality alone cannot . . . give meaning to these demands" (168). Rather, "religious cultures alone . . . can provide the kind of meaning needed" (168). In other words, for Callahan, the demands of caregiving for someone with Alzheimer's disease are so heavy that the person who undertakes them is a hero. Not only is the person a hero, but their sacrifices are so heroic that we cannot even make sense of them with a secular morality.

The case of family caregivers raises the same question about supererogation raised by nurses working during the pandemic, for the resistance to being called a hero also arises. This heroic testimony arises, at least sometimes, insofar as family caregivers believe that they are doing their duty. Evelyn Nakano Glenn collects such claims across various other research about caregiving. For example, Karen Hansen's interviews uncover that even when people have been mistreated by their parents as children, they perceive that caregiving is their duty: "Fran 'accepts caring for her mother as her kin obligation, her duty'" (Glenn 2010, 89; quoting Hansen 2004). And Clare Ungerson asks "Mrs. Fisher, a woman who had cared for her severely disabled husband for twenty-nine years" what motivates her; she replies, "I just think it's my *duty*. I'm a Lancashire lass; all Lancashire people are like that" (Glenn 2010, 89; quoting Ungerson 1987). Kalyani Mehta and Thang Leng Leng (2017, 380) call this the "sense of filial obligation to care.". Their qualitative interviews also include heroic testimony by caregivers, with statements such as, "I don't have a choice, do I? . . . I'm just doing my duty," and "I believe it is my duty" (Mehta and Thang 2017, 380).[9]

4C. Standard Approaches to Heroic Testimony

Traditionally, there are three overarching ways to interpret "I'm not a hero: I was just doing my duty." All three, however, present a puzzle for one who thinks that, *prima facie,* caregivers' testimony should be trusted and taken at face value, for each either attributes a vice to caregivers, denies the extraordinary nature of their sacrifice, or discredits their experience of being morally compelled to care.

The first standard interpretation is a response that Urmson (1958, 203) is apt to give: those who give heroic testimony may be exhibiting false modesty. The problem with this interpretation is that heroic testimony is often accompanied by ire (for example, see the nurse quoted above: "I don't need a compliment; I need safe staffing" [Wallis 2020]). False modesty is not an angry response. Moreover, to attribute false modesty to caregivers is to attribute some sort of vice, such as deceit or fishing for compliments. I cannot argue for the claim here, but I hope it is easy to see that for these caregivers, all things equal, it is better to have a solution that does not attribute to them a vice.[10]

The second interpretation says the heroic testimony is correct. Vanessa Carbonell gives a solution that falls into this category: people who devote their lives to heroic acts, she claims, change the nature of moral obligation by providing evidence that things that seem supererogatory are in fact duties. They only seem heroic to those who have not yet seen the relevant evidence (Carbonell 2012, 228). Additionally, she argues that what counts as a duty depends in part on what the agent knows; heroes know more than everyone else, so they are correct to say they are doing their duty, and the perception that they are doing something supererogatory can be explained away (Carbonell 2016, 37; see also Flescher 2003). The problem with this interpretation is that it says that the caregivers are not making enormous sacrifices. Some people who perform seemingly heroic actions may be providing evidence that the actions are duties and that the sacrifices are, contrary to

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[9] The perceived obligation to care has been documented across many cultures. See, for example, Lindeza et al. (2020), Al-Zyoud, Maharmeh, and Ahmad (2021), Narayan et al. (2015), and Cheung et al. (2020) for representative cases.

[10] Archer and Ridge (2015) also address the phenomenon of heroic testimony, arguing that people who give it lack moral wisdom about their actions but also possess more moral depth. This perspective is more amenable to my view, since it casts caregivers in a better light. Their view, however, is designed to answer a particular paradox that is not the concern of the present paper.

appearances, trivial, but it would be absurd to suggest that this is true of the caregivers here.

The third interpretation is that caregivers are mistaken when they give heroic testimony. The caregivers were not merely doing their duty on this alternative. Urmson (1958, 204) is also apt to give this response, saying they may have mistaken perceptions about the situation. But this option discounts the fact that at the same time, society treats their caregiving as a duty. Additionally, this option undermines caregivers' experience of feeling morally compelled to care, and it undermines their knowledge that they are also likely to be blamed[11] if they don't give care on the grounds that they have not met their duties.[12]

On standard accounts of heroic testimony, therefore, we are not able to say both that caregivers are correct when they give heroic testimony and that their caregiving involves enormous sacrifice, unless we attribute false modesty to them or say they weren't doing their moral duty. That is, the standard accounts of heroic testimony cannot accommodate all three of these claims at once: (1) caregiving involves enormous sacrifices, (2) caregivers recognize they are doing their duties, and (3) their claim is neither a confusion about their duties nor false modesty. To accommodate all three things at once, we need another interpretation of heroic testimony. In the following section, I argue that heroic testimony can better be seen as a response to compulsory heroism.

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[11] I grant that people who do heroic actions might be blamed incorrectly for many reasons, including the possibility that they are in a morally charged situation, where the alternative is suberogatory (Driver 1992) and the possibility that they are acting out of moral necessity (see Archer 2015). Whether or not the blame is attributed correctly is not at issue here. The relevant point is that the caregiving is treated as a duty not only by the caregivers but by society at large, so to say that caregivers were not doing their duty involves attributing to them fundamental misperceptions.

[12] A fourth interpretation is that people hold themselves to a higher standard than others would, not because they are mistaken about the standards but rather because moral requirements flow from subjective values; so to the extent that we have different values, we have different moral reasons. Although this interpretation is consistent with the standard account of supererogation, I set it aside here because, in my cases, the fact that caregivers would typically be blamed by others for not caregiving shows that the values and reasons are in accord. I owe thanks to an anonymous reviewer for explaining both the possibility and why it does not undermine my account.

5. Puzzle Two Solution: Compulsory Heroism

To delineate compulsory heroism,[13] DeVolder examines "overcoming stories" in the context of disability studies, a discipline that has critiqued the overcoming narrative for some time. Overcoming stories are a narrative trope wherein someone is portrayed as beating the odds, overcoming a challenge, and emerging as a victorious hero. In disability studies, the overcoming narrative is labelled the "supercrip narrative" (Silva and Howe 2012, 174). Supercrips are "those individuals whose inspirational stories of courage, dedication, and hard work prove that it can be done, that one can defy the odds and accomplish the impossible . . . presenting the disabled person as heroic by virtue of his or her ability to perform feats normally considered not possible for people with disabilities or by virtue of the person living a 'regular' life in spite of a disability" (Silva and Howe 2012, 174–75). DeVolder argues that the overcoming stories imposed on those with disabilities engender the phenomenon of compulsory heroism.

For DeVolder, compulsory heroism has four primary aspects, which I explain in detail below. I call these the *unwanted* aspect, the *devaluing* aspect, the *defined social roles* aspect, and the *masking social issues* aspect. The first reflects the fact that the label of hero is given regardless of whether it is wanted. The second reflects the fact that the attribution of heroism serves the label-giver at the expense of the label-recipient. The third points to the fact that the label "hero" manifests a social organization of roles as opposed to an individual choice of role, and the fourth indicates that the label masks the social obstacles that give rise to the actions that are labeled heroic.

Consider the *unwanted* aspect. DeVolder (2013, 748) says that in compulsory heroism, the heroism is "bestowed regardless of protests." So-called heroes say they did what they had to do, but then this is taken as humility and therefore evidence of further heroism (748). Carla Filomena Silva and P. David Howe (2012, 175), in their discussion of Paralympian athletes, say that "social expectations are so low for individuals with a disability that any positive action may induce praise from others." The disabled comedian David Roche says, "People are inspired no matter what you do. I could go out and take a dump, you know? And people will say, 'Oh, you're so

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[13] The phrase "compulsory heroism" draws on Adrienne Rich's influential paper "Compulsory Heterosexuality and Lesbian Existence." Rich (1980, 637) characterizes the compulsory nature thus: "violent strictures . . . enforce women's total emotional, erotic loyalty and subservience to men." For Rich, the purpose of compulsory heterosexuality is "a means of assuring male right of physical, economical, and emotional access" (647). Rich thereby lays groundwork for seeing that some social positions are foisted upon certain members of society for the benefit of others.

courageous'" (Roche, quoted in DeVolder 2013, 748). Heroism is bestowed regardless of protests: the recipient's perspective is discounted.

The *devaluing* aspect of compulsory heroism, according to DeVolder (2013, 749), is the feature whereby the label "inherently resists critique." Other people derive hope and meaning from positioning people as heroes. The Paralympics are portrayed as uplifting, and these portrayals generate a sense of ethical superiority. Jan Grue argues that people with disabilities are often the objects of "inspiration porn," a term probably coined by but certainly popularized by the late comedian Stella Young, meaning "the representation of disability as a form of disadvantage that can be overcome for titillation of other people/observers" (Grue 2016, 838). Compulsory heroism, therefore, resists critique by generating this type of inspiration, which is presented as ennobling, uplifting, and morally superior while really in fact masking a kind of objectifying and devaluing porn.

The third characteristic—the *defined social roles* aspect—shows that compulsory heroism is a strategy of normalization. By that, DeVolder means that it is the only given social role; it is a stereotype that, due to a lack of viable alternatives, is not able to be resisted: "I understand compulsory heroism, in the present context, as the main social role available, not only to persons with disability, but also to anyone facing 'adversity'" (DeVolder 2013, 750). Here DeVolder means that heroism is "naturalized"; in other words, heroism is expected and is the default mode of encountering adversity. Any other mode of response is abnormal or deviant and hence not a real or equally worthy choice. You're either a hero or you're one of those bad disabled people who doesn't conform to the social role given to you, the thinking goes. Robert McRuer (2017, 370) similarly notes that disabled/nondisabled are not "equal and opposite identities." Hero and nonhero are also not equal and opposite identities.

DeVolder's fourth characteristic of compulsory heroism—the *masking social issues* aspect—has to do with the way compulsory heroism simplifies and obfuscates the social obstacles that require overcoming in the first place. She says, "Compulsory heroism robs us of a legitimized space to . . . bear witness to stigma . . . and institutional violence. . . . [It] obscures social contexts, social histories, and material realities, like the present realities of declining supports and differential access to resources. . . . It co-opts discourses of empowerment . . . for financial and/or political ends" (DeVolder 2013, 750). Calling a person who relies on a wheelchair a hero for navigating inaccessible buildings and streets, for example, draws attention away from the inaccessibility and from the social structures that make using a wheelchair difficult.

In sum, compulsory heroism occurs when a person is made out to be a hero as a form of what we might call *poisoned praise*.[14] The label seems like praise, and may even be intended as such, but it has the effect of abdicating responsibility for the socially caused difficulties that the so-called hero faces. Often, poisoned praise has the effect of placating the one who praises. In these contexts, the so-called heroes may disavow the label. The disavowal may stem from a sense that heroism is foisted upon them, a sense that the social context is unjust, a sense that one is being used for inspiration porn, or a sense that since one would be blamed if they didn't do the action, the label is hypocritical.

DeVolder identifies compulsory heroism in the context of the supercrip narrative. In that narrative, the problem with compulsory heroism is that people are patronizingly made out to be heroes for doing ordinary things. But the cases of caregiving I have examined involve compulsory heroism when the caregivers are making enormous personal sacrifices while doing their duty due to systemic and ongoing issues. Perhaps, then, heroic testimony is a resistance to the compulsion in compulsory heroism. Since these cases of compulsory heroism are the ones that are involved in the question of heroic testimony, I shall now argue that they also involve compulsory heroism.

First, consider nurses in the early stages of the COVID-19 pandemic. In their statements cited above, we see indications that compulsory heroism is present. The hero label is a distraction from social issues, gender issues, and exploitation generally (*masking social issues*), it serves the society at the expense of nurses (*devaluing*), it perpetuates stereotypes about what a nurse must be like (*defined social roles),* and it invokes ire (*unwanted*).

So, too, with family caregivers. An American Association of Retired Persons list of things you ought not say to caregivers advises against elevating caregivers with labels like "saint" as "taboo"; labels like "hero," with a similar function, are thus *unwanted* (Goyer 2019). The *masking social issues* aspect of compulsory heroism is also present, as seen by the above partial list of vulnerabilities family caregivers face. The *devaluing* aspect of compulsory heroism occurs when the label of hero serves the person who gives the label at the expense of the recipient. For family caregivers, the label of hero is not experienced, as it is in the case of disability, as inspiration porn; instead, the label is better seen as placing the caregiver on a pedestal, distancing her from the moral community.[15] Finally, the *defined social roles* aspect of compulsory

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[14] See Jules Holroyd's (2021) "Oppressive Praise" for an account of how praise can entrench existing oppression.

[15] Many philosophers argue that freedom and moral responsibility come from being in a position where moral address is possible (see, e.g., McKenna 2012; Strawson 1974). Newborns, for example, are not morally responsible because they cannot

heroism is present. Glenn (2010, 88) notes that "the pattern [in which women are the default caregivers] is so pervasive that it tends to be taken for granted as the natural order of things rather than being recognized as a socially created arrangement."[16]

If caregiving involves compulsory heroism, then an alternative interpretation of heroic testimony is possible, one that opens the door for neither attributing a confusion on the part of caregivers, nor diminishing their sacrifice, nor attributing false modesty. In compulsory heroism, a person must make enormous all-things-considered sacrifices to do what they perceive to be their duty. This means that when a caregiver says, "I'm not a hero; I was only doing my duty," the claim is in part a resistance to compulsory heroism, a reaction to the fact that being called a hero takes attention away from the fact that the caregiving is socially arranged in a way that makes it involve such enormous sacrifice to perform an unvalued, exploitative social role that is perceived to be one's duty. Concerning caregivers, the compulsory-heroism interpretation of heroic testimony is superior to the three traditional interpretations explained above.

In fact, we can now see that the solutions to both puzzles are related. The standard account of supererogation does not allow for the possibility of things that are both duties and supererogatory, so it says that caregivers are either mistaken in their perception that caregiving is their duty, or they are not doing something supererogatory (if they aren't expressing false modesty). Dorsey's account of supererogation allows for supererogatory actions that are one's moral duty, so it allows for the possibility that heroism and moral duty are compatible, thus making room for the compulsory-heroism interpretation of heroic testimony. Under this interpretation, resistance to the hero label manifests a resistance to social arrangements that make moral duties involve enormous sacrifice; the disavowal of heroism is an expression of ire directed toward the compulsory nature of the heroism, toward the fact that social arrangements make moral duties involve so much self-sacrifice.

If caregivers believe they are making enormous sacrifice while doing their duty, then we should consider the possibility that duty and heroism are compatible, that caregivers *are* in fact, heroic while doing their duty, and their disavowal of the heroism label, instead of being a denial that they are making enormous sacrifices, is instead a rejection of the compulsory nature of compulsory heroism. People don't like to be in a position where doing their moral duty has so many enormous prudential

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participate in the give-and-take that moral conversation generates. Arguably, placing someone on a pedestal removes her from the moral community, distancing her and thus removing responsibilities to her. A hero, not being one of us, does not share our needs and thus does not require our help.

[16] Indeed, Glenn's book is entitled *Forced to Care: Coercion and Caregiving in America*.

sacrifices, including basic health and safety. Hence, by making room for saying that heroes can make enormous sacrifices to do their moral duty, Dorsey's account of supererogation can account for these relatively widespread cases of caregiving, which in turn allows for an explanation of caregiver heroic testimony, which is also widespread, that does not attribute a vice or confusion to caregivers or diminish their sacrifice.

6. Conclusion

The correct understanding of supererogation is not a merely theoretical issue with little practical import. Rather, the new account of supererogation can make sense of relatively uncontroversial perspectives about many caregivers: they are doing their moral duty, yet due to ongoing and systemic social issues, they are also making tremendous sacrifices such that their actions are also supererogatory. Additionally, caregivers are subject to compulsory heroism: they are called heroes (not necessarily consciously or intentionally) as a way of masking the issues that make doing their moral duty involve enormous sacrifices to their well-being. Calling them heroes masks the social obstacles they face in doing their supererogatory moral duty. The concept of compulsory heroism can make sense of heroic testimony without attributing misperception or false modesty to caregivers and without diminishing their sacrifice. Understanding supererogatory moral duty and compulsory heroism demonstrates that for caregivers, something needs to change. Indeed, many things do: the way we view and exploit unpaid labor, the gendered division of labor, and exploitation in the workplace are just a few.

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