

ALISA L. CARSE

THE 'VOICE OF CARE': IMPLICATIONS FOR BIOETHICAL EDUCATION

ABSTRACT. This paper examines the 'justice' and 'care' orientations in ethical theory as characterized in Carol Gilligan's research on moral development and the philosophical work it has inspired. Focus is placed on challenges to the justice orientation – in particular, to the construal of impartiality as the mark of the moral point of view, to the conception of moral judgment as essentially principle-driven and dispassionate, and to models of moral responsibility emphasizing norms of formal equality and reciprocity. Suggestions are made about the implications of these challenges, and of the care orientation in ethics, for the ethical theory taught, the issues addressed, and the skills and sensitivities encouraged through bioethical education.

Key Words: bioethical education, ethics of care, impartiality, moral judgment, moral psychology

INTRODUCTION

When Carol Gilligan published *In a Different Voice* in 1982, she claimed to hear a 'distinct moral voice' in the reflections of the women subjects she interviewed for her research on moral development. Gilligan dubbed this 'voice' the 'voice of care' and contrasted it with the 'voice of justice' expressed in standard ethical theories rooted in Kant and the contractarians. Gilligan's research was designed in part as a corrective to the research of Piaget (1932) and Kohlberg (1981, 1984), whose studies of moral development initially excluded women, and later found women to be 'less developed' morally than men and who, in their research, equated morality with the 'justice' approach simpliciter. Gilligan's research and the work it has inspired in psychology and philosophy have given rise to a set of challenges, both to orthodox theories of moral development and to dominant strains in ethical theory. I want to examine and motivate a number of those challenges to ethical theory and to identify their implications for bioethics and education.¹

Alisa L. Carse, Philosophy Department, Georgetown University, Washington, DC 20057, U.S.A.

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'JUSTICE', 'CARE', AND GENDER

It is most helpful to understand the two moral 'voices' as distinct *orientations* within morality. These orientations are distinguished by differences in the reasoning strategies employed and the moral themes emphasized in the interpretation and resolution of moral problems; they represent distinct moral sensibilities and "different moral concerns" (Gilligan, 1987, pp. 22–23; Gilligan *et al.*, 1988, p. 82).

According to Gilligan, the justice orientation construes the moral point of view as an impartial point of view, understands particular moral judgments as derived from abstract and universal principles, sees moral judgment as essentially dispassionate rather than passionate, and emphasizes individual rights and norms of formal equality and reciprocity in modelling our moral relationships. By contrast, the care orientation rejects impartiality as an essential mark of the moral, understands moral judgments as situation-attuned perceptions sensitive to others' needs and to the dynamics of particular relationships, construes moral reasoning as involving empathy and concern, and emphasizes norms of responsiveness and responsibility in our relationships with others. Whereas we are, on the justice orientation, viewed as individuals first, and in relationship to each other only secondarily, through choice, we are, on the care orientation, understood as *essentially in relationship*, though no single kind of relationship is endorsed as alone morally paradigmatic.²

Now it is important to note, first, that Gilligan herself denies that the justice and care orientations correlate strictly with gender. She reports that recent studies show both women and men capable of shifting easily from one orientation to the other when asked to do so, though it is women who are most likely to exhibit a dominant care orientation – a tendency, that is, for the terms of care to take precedence over those of justice in their approach to moral problems (Gilligan *et al.*, 1988).

Second, Gilligan claims that the justice and care orientations are not mutually exclusive: "Like the figure-ground shift in ambiguous figure perception, the perspectives of justice and care are not," she says, "opposites or mirror-images of one another, with justice uncaring and care unjust. Instead, these perspectives denote different ways of organizing the basic elements of moral judgment: self, others, and the relationship between them" (1987,

pp. 22–23). I will investigate this claim critically later, because it appears to underestimate the degree of tension between the two orientations as Gilligan describes them.

My concern in this discussion is with the implications for ethical theory generally, and for bioethics in particular, of Gilligan's characterization of these two moral orientations. It is not on the empirical status of the differences Gilligan claims to have found between male and female moral reasoners that I will focus, but on the different modes of moral judgment her work has highlighted. As Marilyn Friedman has aptly put it, "the different voice hypothesis has a significance for ethical theory and ethics which would survive the demise of the gender difference hypothesis. At least part of its significance lies in revealing the lopsided obsession of ... contemporary theories of morality with universal and impartial conceptions of justice and rights" (1987, p. 92).

Along these lines, I want to emphasize that we must steadfastly reject any suggestion that women speak in one moral voice; such a claim would be preposterous at best. And we must be wary of the tendency toward gender-essentialism that the language of gender difference can, even unwillingly, invite.³ Moreover, we need not, in the end, deny the crucial importance of justice and rights in affirming the wisdom and value of the voice of care. We might, that is, defend the need to retain a sturdy rights conception within ethics, but affirm at the same time the need for an ethic more demanding than the ethic of justice – one which gives an essential place to 'care' through norms of character and citizenship (for all people), traditionally thought more appropriate for women than for men.

Most deeply at stake in the care-oriented challenge is the conception of the moral subject, of the capacities and skills constitutive of moral maturity. The question thus naturally arises what implications the challenge has for ethical education, which aims to nurture and encourage moral capacities and skills. My aim is first to set out the broad contours of the challenge and then to explore a number of implications the challenge has for bioethical education.

What are the chief criticisms leveled against the justice orientation by care theorists? There are four that get to the heart of the matter, corresponding to the four points of contrast listed above.

IMPARTIALITY AS THE MARK OF THE MORAL

Recall that a first feature of the justice perspective is its commitment to impartiality as the hallmark of the moral point of view (the point of view from which moral judgment is rendered, moral choice is made). On the justice orientation, we are to refrain from giving special weight to our particular values and preferences, personal attributes, relationships, and situations, or for that matter to anyone else's either, in determining what morality demands. On this construal of impartiality, the benefit a course of action might have for me, my child, or my neighborhood, for example, is not itself deemed relevant to the moral justification of that course of action. The impartiality requirement, so understood, captures the intuition that what is morally required of one person is morally required of any person relevantly similarly situated. Moral demands don't favor any one in particular, or any particular relationship as such. We can see the relationship between the impartiality requirement, so understood, and the conception of moral principles as abstract and universal in scope (Rawls, 1972; Kohlberg, 1981).

Seyla Benhabib has called the impartial moral standpoint the standpoint of the "generalized other" (1987, p. 163). From this standpoint we view every individual as an independent, rational agent entitled to the very same rights to which we ourselves are entitled as independent, rational agents. In taking this standpoint, I might acknowledge that the other has a unique life history, particular affections, attachments, commitments, and aspirations; however, what grounds the other's moral claim on me is not any of these particular identifying features, but the fact of his or her personhood itself. Thus, from the impartial point of view, I can acknowledge the other's *personhood*, in an abstract sense, but not his or her distinctive identity as a person.

Now, the impartiality requirement is seen by feminist critics as morally problematic precisely because it requires abstraction away from the concrete identity of others and our relationships to them. Gilligan writes: "As a framework for moral decision, care is grounded in the assumption that ... detachment, whether from self or from others is morally problematic, since it breeds moral blindness or indifference – a failure to discern or respond to need" (1987, p. 24). The worry is that in taking an impartial standpoint, I become unable to see into the other's position, to imagine myself

in the other's place, and thus to understand the other's concerns or needs; "the other as different from the self disappears" (Benhabib, 1987, p. 165). The care orientation champions a close attentiveness to particularities of identity and relationship as a crucial feature of moral understanding, claiming that without such attentiveness we are, in many cases, in no position to render moral judgment or make a moral choice at all. The impartial observer is *disqualified* rather than *legitimated* as a competent moral judge (cf. Gilligan, 1984; Held, 1987; Murdoch, 1970; Ruddick, 1989).

One might attempt to defend the traditional commitment to impartiality by arguing that it is properly to be understood as a *justificational* constraint, not a constraint on all moral deliberation. We might, that is, hold that impartiality is crucial to the evaluation and justification of moral requirements (or recommendations), without thereby holding that impartially justified moral requirements (or recommendations) always enjoin moral agents to take an impartial point of view in going about their lives (Hill, 1987). Both deontologists and consequentialists have standardly required that moral prescriptions be justified from an impartial standpoint. But nothing prohibits prescriptions so justified from acknowledging partial duties and special obligations, pertaining, for example, to people in virtue of the roles they inhabit (e.g., physician, nurse, teacher, or governor) or the specific relationships in which they stand to others (e.g., spouse, parent, friend, or fellow patriot).

An adequate response to this line of thought is impossible here. Let me just say, first, that the feminist criticism of impartiality is best understood as the claim that there is no single or privileged justificational standpoint in morality. If one is contemplating what responsibilities one has generally as a teacher to one's students or as a physician to one's patients, appeal to impartially justified principles may be illuminating and appropriate. If one is trying to decide how to respond to a particular student's truancy, or to a particular patient's refusal of treatment, attunement to the peculiarities of individual need and to the vagaries of circumstance may be essential to sound moral judgment. The *broad* requirement that we attend to the particularities of others and our relationships to them can itself be validated from an impartial point of view – one which privileges no one in particular and no particular group or relationship as such (Sher, 1987). However, the

justifiability of impartially justified prescriptions must be subject to assessment with an eye to particulars. The suggestion, then, is that impartial prescriptions cannot always inform us sufficiently about how to respond to others, and morally relevant features of particular situations will sometimes be obscured through an overzealous reliance on impartial prescriptions, even those that recognize special obligations and duties. This is not to deny that impartial deliberation is sometimes appropriate to moral justification; it is rather to claim that the impartial point of view has no special authority as such in determining the moral validity of our judgments or the assessment of moral requirements and recommendations.

More broadly, the rejection of impartiality as the mark of the moral is a rejection of the prevailing tendency in ethical theory to construe, as morally paradigmatic, forms of judgment that abstract away from concrete identity and relational context, and to view moral maturity and skill as residing essentially in the capacity for abstract judgment so construed. The focus on impartiality as the hallmark of moral judgment has had the effect of ascribing a derivative, secondary status to forms of epistemic skill – involving attention to nuance and peculiarity – that are, from the perspective of care, often of the first importance.

MORAL JUDGMENT AS PRINCIPLE-DERIVED

This first challenge to the justice orientation leads us to a second. Recall the conception of moral judgment within the justice perspective as principled judgment. Moral conclusions about what to do in particular cases are depicted as derived from general principles or rules of conduct. The care orientation is characterized by a general antipathy to moral principles. At one point, Gilligan describes a moral judgment as “a contextual judgment, bound to the particulars of time and place ... and thus resisting all categorical formulation” (1982, pp. 58–59). The resistance to principles coincides with the rejection of impartiality as a (necessary) mark of moral judgment; to act on principles is just to act for reasons that are taken to hold with the same force for all others who are similarly situated. But there is some confusion about the nature of principles and the role principles can (and cannot) play in moral judgment. Thus, I want to try to motivate the movement away from a conception of moral judgment as

essentially principle-driven while in the end acknowledging a reduced, but important, role for moral principles, properly understood.

An extreme conception of principled judgment asserts, with Kant, that principles admit of no exceptions. Let us consider, however, a less extreme conception of principles according to which they have *prima facie* status, for this is the conception generally used in bioethics (cf. Ross, 1930; Beauchamp and Childress, 1989; Beauchamp and McCullough, 1984). On this conception, no single principle is granted absolute priority in cases of conflict. Rather, the weight of principles must be assessed as cases arise, and any principle can on some conditions be overridden. On this construal of principled reasoning, an apprehension of contextual detail and a willingness to tailor moral judgments to the particulars of context does not amount to an abandonment of principles. Quite the contrary, sensitivity to contextual detail is necessary in order to apply principles to particular situations.

The question thus arises, Why not maintain a conception of moral judgment as principle-driven, even within a care orientation? The answer lies in the limited usefulness of principles in informing and guiding a caring response. This can be seen in several ways.

First, there arises a general point about principle application. Recognizing that a general principle or rule is relevant to the situation at hand, and knowing how it is fittingly to be acted upon requires a capacity for discernment that is *distinct from*, and *presupposed by*, the application of principles themselves. Consider the apparently simple injunction to be kind to other people. What does meeting this injunction amount to? Being kind is no mechanical matter. A kind response in one situation could be an intrusive or meddlesome response in another. Now we might generalize about what kind people do: kind people, for example, tend to try to cheer up their friends when their friends are sad, to help people pick up the groceries they have dropped, to comfort others who are suffering, and the like. But there are no principles or rules to guide such actions; those judging must be responsive to particular nuances of situations as they arise. Being a kind person is, among other things, being disposed to 'see' that one's friend needs cheering up or that, in *this* case offering a hand with the groceries would be helpful rather than meddlesome. To be kind is, among

other things, to be capable of interpreting when a situation is one in which kindness is called for and what being kind amounts to in that situation.⁴ An account of moral judgment according to which it consists in the deductive application of general principles (even *prima facie* ones) to particular cases does not alone provide an adequate picture of how we come properly to interpret situations and judge what we ought to do (Nussbaum, 1985; Sherman, 1990b).

Moreover, as the kindness example illustrates, it is, within the care orientation, not just a sensitivity to the particular features of context that is integral to moral judgment, but more specifically, a sensitivity to *other people*, a capacity to perceive (as best we can) how others feel, and how they understand themselves and their circumstances. Attention must be given to the unique and unrepeatable features of other persons, our relationship to them, and the circumstances in which we find ourselves with them. This attention, and the discernment of particulars it involves, is itself a *moral capacity* which can be developed and exercised with greater or lesser success and which, crucially, is not itself principle-governed.

Because the injunction to give care generally requires that we be attuned in certain (caring) ways to the particular and unique contours of situations as they come up, and more particularly, to *other people*, an account of moral judgment as principle or rule-derived cannot, in an ethic of care, provide a full picture of how we come properly to judge what we ought to do.

This is not to say, however, that there is no role for principles to play in a care orientation; principles may prove indispensable. For they can help to activate virtuous perception by calling to mind broad norms of conduct and thereby aid us in articulating at least some of the moral stakes of our decisions. They can also provide crucial checks on our pursuit of others' welfare. But an appeal to principle can not alone establish the moral validity of particular judgments, for the appeal to principle is itself valid only insofar as decisions based on the principle are good ones. Establishing this will require a discernment of the particulars (Nussbaum, 1985; Aristotle, *Nicomachean Ethics* 1113^b13^{ff}. in McKeon, 1941). And properly discerning the particulars will require the exercise of specific forms of affective and cognitive skill – of emotional attunement and sympathetic insight which are not themselves principle-governed.

This brings us to another, related point. When we 'see' that the child crouched in the corner wants to be approached and touched rather than called to or left alone, when we speak more softly to quell someone's fear or comfort someone in pain, or look away from someone who has just been humiliated, our response to the other may be direct and dispositional rather than indirect and deliberative. Though I may come to avert my eyes from someone through a process of principled deliberation, I might also avert my eyes spontaneously, in direct (non-deliberative) response to his distress. Similarly, I might approach and touch someone or modulate my voice 'without even thinking'. Practically attuned responses to situations are not always grounded in forms of explicit awareness or undertaken as a result of principled deliberation. They can be the result of practical insight that is dispositional and non-interferential, a *sympathetic attunement* to others' needs or concerns which directly informs our response to them.

This suggests that it is not only the case that principled moral deliberation involves the exercise of discernment that is not itself principle-directed, but also that principled deliberation is not itself always integral to generating a caring response to others.

MORAL INTELLECTUALISM

This brings us to a third feature of the feminist challenge, namely, the challenge to the intellectualism of the justice orientation and a correlative assertion of the centrality to the moral personality of well-cultivated emotion. This general challenge raises complex and highly controversial issues which I can only touch on here. It is useful to understand the challenge as having two dimensions: the first concerns the importance of the emotions to moral discernment; the second concerns the importance of emotion, and in particular, the expression of emotion, to moral response (Nussbaum, 1985, esp. pp. 183–193; Sherman, 1990a, 1990b).

How are the emotions important to moral discernment? The suggestion is that it is often through our emotions that we discern the condition of others; insight into the feelings and concerns of others is not a deliverance of the intellect alone. Our own capacity for humiliation can, for example, tune us in to the fact that someone else is being humiliated, rather than merely ribbed or teased. Through empathy or compassion, we may recognize

another's pain or discomfort, even when its manifestations are subtle or masked. Similarly, anger, surprise, anguish, fear, embarrassment, grief, joy, yearning, and sympathetic versions of these, are ways of being attuned to situations, *modes of attention*, in virtue of which certain features of a situation stand out for us and others recede from our attention.

To view the emotions, as they often are viewed in ethical theory, as agitations or disturbances of moral judgment – messy encumbrances of the moral self that need not concern us so long as they are kept subject to the control of a rational will – is to overlook the crucial role emotions can play, when properly cultivated, in alerting us to morally salient dimensions of situations (Murdoch, 1970; McDowell, 1979; Blum, 1980).

In addition to their role in moral discernment, the emotions play an important expressive role in moral response. As the example of kindness illustrates, it is not just *what* we do, but also *how* we do what we do, that can make a moral difference in giving care; and this is reflected in our gestures, our tone of voice, where and how we stand or move, how we listen – crucially, the emotions we do (or don't) express. Expressing the right emotions at the right time in the right way is, on this view, an integral feature of moral agency (Aristotle, *Nicomachean Ethics* 1106b21–23 in McKeon, 1941). It is important to distinguish this point from the claim that we ought to act *out of* good motives, out of interest and concern for the other. The emotional quality of our response to another is not just a matter of the motivation out of which we act; it is also a matter of the *manner* in which we act. This is an important distinction, for the treatment of emotion in ethics is standardly confined to an assessment of the motives of action. Yet it can be morally significant not just that one acts, for example, from sympathetic, considerate, or kind motives, but that one acts sympathetically, considerately, or kindly, that is, in such a way as to *express* sympathy, consideration, or kindness in acting (Sherman, 1990b).

It appears, then, that we are not simply in need of an enriched normative vocabulary in terms of which to address those skills and capacities agents require in order effectively to *apply* general principles or rules of conduct to particular cases. We are also in need of an account of those skills and capacities agents need in order effectively to *discern* what morality demands, encourages, or recommends and, having done so, to conduct themselves in the

proper *manner*, to express themselves effectively and appropriately.

Thus, it is clear that the emphasis on impartial, principled, and dispassionate judgment that marks the traditional justice orientation will fall short of providing adequate guidance within an ethic of care. A key element of the care orientation in ethics, as the philosophical analysis of care is further developed, will need to be an account of the skills and character traits – the virtues – which constitute the caring person. Insofar as care theory infuses bioethical theory, more attention will need to be given in bioethical theory to the virtues relevant to caretaking within medical and nursing practice. And among the virtues will be certain cultivated emotional capacities.

MODELLING OUR RELATIONSHIPS

Let us turn now to a fourth feature of the justice orientation to which the challenge of care theory has been directed, namely, the emphasis within this orientation on norms of formal equality and reciprocity in treating the morality of human relationships. Annette Baier writes,

It is a typical feature of the dominant moral theories and traditions, since Kant, or perhaps since Hobbes, that relationships between equals or those who are deemed equal in some important sense, have been the relationships that morality is concerned primarily to regulate. Relationships between those who are clearly unequal in power, such as parents and children, earlier and later generations in relation to one another, states and citizens, doctors and patients, the well and the ill, large states and small states, have had to be shunted to the bottom of the agenda, and then dealt with by some sort of 'promotion' of the weaker so that an appearance of virtual equality is achieved. Citizens collectively become equal to states, children are treated as adults-to-be, the ill and dying are treated as continuers of their earlier more potent selves, so that their 'rights' could be seen as the rights of equals (1987a, p. 53).

The commitment to equality can sometimes be indispensable in ensuring that those more vulnerable and less powerful are protected against forms of harm, for example, exploitation or neglect. But as Baier notes, this commitment also covers over, 'masks', the nuances of those relationships between people of unequal power or one-sided dependence, and the special moral demands weakness or dependency can introduce into a relationship:

A more realistic acceptance of the fact that we begin as helpless children, that at almost every point of our lives we deal with both the more and the less helpless, that equality of power and interdependency, between two persons or groups, is rare and hard to recognize when it does occur, might lead us to a more direct approach to questions concerning the design of institutions structuring these relationships between unequals (families, schools, hospitals, armies) and of the morality of our dealings with the more and the less powerful (1987a, p. 53).

The relative weight given to relations among 'equals' has led to *silence* in moral theory about good and bad kinds of engagement in relationships characterized by material inequality – of power, of knowledge, of vulnerability (as with the sick or young or dependent).

This criticism is related to a second, directed to the rights-based model of moral relationship and the individualistic conception of the self. In particular, the centrality of the right to non-interference in many justice models is based in a commitment to the value of autonomy, and thus of social frameworks within which individuals are ensured the liberty to pursue their (autonomously affirmed) conceptions of the good, consistent with the equal liberty of others. On this view, if you have a right to something, then I have the duty not to impede your pursuit of it. In meeting this requirement, I respect your right to non-interference and I have a legitimate right to demand that you will respect mine. Our interactions are thus marked by a norm of mutual non-interference. What does the emphasis on individual autonomy and the right to non-interference have to do with the individualistic conception of the self? What objections have been raised against these features of the justice orientation?

One worry is that a moral model of our relationships which construes them as paradigmatically structured by rights to mutual non-interference, except when more robust association has been voluntarily assumed, can address very few of our relationships. Just as detachment was seen, from the perspective of care, to threaten us with moral blindness, so non-interference is seen, from the perspective of care, to threaten us with neglect and isolation, especially if we are dependent or relatively powerless, like the very young, the very old, or the sick.

This brings us back to the individualism of the self on the justice perspective. On this perspective, it isn't assumed that we are in relationship, or that human relationship *per se* has value. The existence and value of particular relationships and of human

relationship more generally are treated as resting in individual choice. Relationships are construed as among the autonomously affirmed goods we are, as individuals, to be at liberty to pursue.

Now we do, as individuals, choose *some* of our relationships. We tend, for example, to choose who (if anyone) we will marry or divorce; we sometimes choose friends and often choose the clubs we join. But many of our relationships, and more importantly, of our caring relationships, are not undertaken through choice: we don't choose our parents or siblings, nor do they choose us; and though we might choose to have children, we don't choose the children we have. This holds true of many of our students and patients as well. And though we can reflect critically on the *terms* of our relationships – *how* we relate to others or they to us – we can not, as individuals, independently choose or dictate these terms. Relationships require flexibility and responsiveness on the part of those in the relationship.

Gilligan writes: "As a framework for moral decision, care is grounded in the assumption that the other and self are interdependent" (1982, p. 24); that a good life is one which involves a "progress of affiliative relationship" (1982, p. 170); that "'the concept of identity ... includes the experience of interconnection" (1982, p. 173; cf. Baier, 1987a, 1987b; Bishop, 1987; Ruddick, 1984, 1989). A more adequate moral model of us as individuals would more realistically recognize the full extent of our mutual *interdependence*; it would attend more actively to modes of relating to and being with others that help to sustain good relationships among individuals who are not equal in power and relative dependence (cf. May, 1977, 1983; Pellegrino and Thomasma, 1988).

THE ETHIC OF CARE

Where do these criticisms, if taken seriously, point us? The care critique has both methodological implications, for the *process* of moral reasoning and judgment by which we are to come to understand what morality demands of us, and normative implications, for what it is that morality demands of us.

On the methodological front we have seen that 'care' reasoning is concrete and contextual rather than abstract; it is sometimes principle-guided, rather than always principle-derived, and it involves sympathy and compassion rather than dispassion. This introduces a conception of moral psychology much thicker and

richer in its skills and capacities than the conception needed on the justice perspective and suggests a movement in a more virtue-theoretic direction, in which not only our actions, but also our characters, are a focus of moral attention.

On the normative front, we have seen that the ethic of care asserts the importance of a concern for the good of others and of community with them, of a capacity for imaginative projection into the position of others, and of situation-attuned responses to others' needs. We have also seen moral importance extended from *what* we do, to *how* we do what we do – the manner in which we act, where this includes the emotional quality or tone of our actions as integral to moral response. Finally, we have seen a call for more moral acknowledgement of our mutual interdependence, of the actual limitations of material equality, and of the special responsibilities vulnerability and dependence can introduce into our relationships.

Both the methodological and normative implications of the care critique suggest that the differences dividing the two perspectives concern much more than emphasis; they concern our conception of the most fundamental elements of moral life: moral judgment, the nature of the moral self, and our responsibilities as individuals to each other.

There are strong theoretical precedents for the care perspective, so understood. A historical alternative to the deductive, principle-driven account of moral judgement is found in Aristotle, for example, for whom moral deliberation involves practical wisdom, which is understood to outrun any general rules or principles one might possibly devise (*Nichomachean Ethics* 1104a1–9 in McKeon, 1941). Moreover, Aristotelian virtue consists in dispositions to passion as well as action, feeling the right emotions “at the right times, with reference to the right objects, towards the right people, with the right motive, and in the right way” (*Nichomachean Ethics* 1106b21–3, 1109b30 in McKeon, 1941). The care orientation also finds a kindred spirit in David Hume, who criticizes Hobbes and Locke for what he calls their “selfish systems of morals” and who views corrected sympathy, not principled reason, as our basic moral capacity (Baier, 1987b).

BIOETHICS AND EDUCATION

I want, in this section, to identify some implications for bioethics

and education of the preceding challenges to the justice orientation in ethical theory. There are some clear affinities between standard approaches taken in bioethics and the justice orientation that care theorists characterize. Bioethical theories tend to take a principle-based approach on which moral judgments are construed to be directed paradigmatically to the question "What ought morally to be done?" and thus to be concerned primarily with right action, rather than good character or virtue. Bioethical theories tend largely to emphasize, as fundamental, the impartial principles of respect for autonomy, justice, and beneficence. Much current debate in bioethics is between deontologists and utilitarians, and concerns how we are to understand and rank the importance of these principles.

It is true that the importance placed on beneficence in some bioethical theories may seem to make these theories morally richer than the justice orientation challenged by care theorists. For the principle of beneficence requires us to do more than recognize others' rights to non-interference; it requires us actively to promote the welfare of others. Nonetheless, there is a notable difference: the care orientation emphasizes sympathy and compassion as modes of concerned attention to concrete and particular others, whereas the principle of beneficence urges a 'love of humanity', an abstract concern for others in virtue of our common humanity.⁵

The fact that case studies are a central focus of bioethical discussion, that discussions of standard bioethical issues such as euthanasia, confidentiality, informed consent, or resource allocation often involve paying attention to the concrete details of particular contexts in which those issues arise, may reinforce in a second way a sense that there are strong similarities between standard bioethical approaches and the ethic of care. It is important to emphasize, therefore, that while bioethics discussions, in virtue of focusing on applied issues, tend to be more concrete than some discussions in theoretical ethics, standard bioethical approaches continue to be abstract in a crucial sense: they rely on a language of abstract rights and principles, and on conceptions of obligation formulated independently of particular contexts. Details of context are consulted only in order to apply abstract, general principles to particular cases.

The care-oriented challenge thus has implications for the ethical theory taught, the issues addressed, and the skills and sensitivities

encouraged through bioethical education. Let me set out seven implications here, as suggestions for further discussion and inquiry.

1. One issue the care-oriented challenge raises for bioethical education is the possible tendency of a bioethical approach that pictures moral judgment as essentially principle-driven to emphasize institutionally developed rights-based codes and procedures and to underemphasize the personal skills and capacities that go into good caretaking. Too much rule-dependence may run the risk of encouraging a curseness of feeling and a lack of care and compassion necessary to fostering hope and ensuring that a patient's good is served in the healing process.

An example of a change in bioethics which is a change in the direction of an ethic of care, is found in more recent treatments of the issue of informed consent – in particular, the shift away from an emphasis on institutional rules of information disclosure toward greater attention to the quality of the patient's understanding and of the communicative exchange. What this shift in emphasis demonstrates is that in a properly caring context, respect for autonomy – the principle which grounds informed consent, will involve not only negative prohibitions against coercion, manipulation and the like, but also positive duties, to nurture and sustain the patient's capacity to exercise autonomous choices. This process requires much more than procedurally correct forms of information disclosure; it requires sensitivity to the individual patient – to his or her fears, hopes, values, and capacities in the decision-making process (cf. Faden and Beauchamp, 1986, esp., Chapter 7; Beauchamp and Childress, 1989, esp., Chapter 3; Pellegrino and Thomasma, 1988).

2. This suggests that more effort should be made to attune students to their own and others' values, fears, capacities and commitments, and to encourage the consideration of such factors in the interpretation and resolution of ethical conflicts. Along these lines, the care-oriented challenge raises the question for educators how we can, through education, widen and expand emotional knowledge and imaginative power, and encourage in our students the capacity to enter into the feelings and perspectives of others. Iris Murdoch recommends the study of literature as a way to learn to "picture and understand human situations" (1970, p. 34). A bioethical education might include exposure, through readings, testimonials, and films to the health

care problems and healing practices of different cultures, religions, and peoples, thereby enhancing students' awareness and sensitivity to others. It might also provide examples of real or fictional people who can inspire or serve as role models, and encourage discussion of both these particular lives and of cultural ideals.

3. On the care orientation, what is sought in ethical debate is not so much theoretically neat, universally justifiable solutions to moral conflicts as shared interpretations of problems and collective success in mediating and balancing the different moral claims and concerns various parties to a case express. If we accept this picture of moral conflict-resolution, more emphasis would need to be placed in bioethical education – particularly of those who will work in the clinical setting (such as physicians, nurses, clinical ethicists, and the like) – on the development of communication skills. We need to ask ourselves as educators what sorts of skills facilitate people in expressing themselves and listening to others, in interpreting what others say or do with insight and understanding. We might pay more explicit attention to the implications of manner, tone, forms of demeanor and expression – for the ability to communicate effectively.

4. A broad implication of the care-oriented challenge – particularly the worries voiced about impartiality – is that bioethical issues ought not to be addressed in a social and political vacuum. Bioethical education should encourage critical reflection on the gender patterned occupational roles among health care providers, on the way in which the roles of physician and nurse, for example, have historically been construed as male and female roles, respectively, and on the effect this has had on the division of labor and authority in health care practice (cf. Warren, 1989, p. 77; Winslow, 1984). This becomes particularly important as more women enter medicine and the nursing shortage becomes an ever greater problem. Bioethical education should also include an examination of the broad social and economic implications of particular medical practices and technologies, such as reproductive technologies, and address the implications both for our access to health care and for our health care needs of factors such as age, gender, class, religion, and sexual orientation (Overall, 1987; 1989, p. 182; Sherwin, 1987, 1989). Ignoring these factors in our ethical reflections can desensitize us to the very real differences in the health care needs particular individuals and groups face.

5. Related to this point, more attention might be paid to the nature and dynamics of particular relationships and relationship-types as significant feature of ethical analysis. The interpretation of cases can involve an acknowledgement of the inequalities of dependency, vulnerability, and knowledge within the relationships that actually structure our lives. Recognition of the inequalities and articulation of the positive duties of care and empowerment they introduce can be an important dimension of bioethical analysis. Students might be encouraged to reflect on various normative models of human relationship that have been proposed in the bioethical literature (e.g., the contract model, the covenant model) and their suitability given the different forms of interdependency and responsibility that characterize relationships between patients and health care providers.⁶

6. Bioethical education must, in the end, affirm the very real moral ambivalence often experienced by all of us, especially by those who wield power in helping others, and guide students in learning to cope constructively with their own and others' sources of moral ambivalence through open dialogue, role-playing, and essay and journal writing (Warren, 1989, p. 84). Along these lines, the scope of moral discourse might be self-consciously and explicitly expanded to include not only what is morally obligatory, but also what is recommended, urged, advised, or encouraged by morality. Invoking a richer moral psychological vocabulary and paying greater attention to contextual peculiarity and social-economic patterns in our analyses of cases and issues, can facilitate the process of articulation and analysis in a way that remains true to the intricate moral and psychological stakes present.

7. Finally, what becomes clear is that from the perspective of the care orientation, moral maturity involves a wide range of perceptual, imaginative, emotional and expressive capacities. This suggests that bioethical discussions should be addressed not only to the question "What is the moral status of this action (or policy for action)?" but also "What kind of person ought I to be?" and "What traits and capacities ought I to develop?". As we have seen, this introduces the need for a richer moral vocabulary, for the ability to address issues of character and virtue as well as right action. But it also suggests that bioethical education would, at its best, be aimed at developing not only intellectual skills and moral theoretical knowledge but the whole character of the moral agent.

It would itself be a kind of "fitness program" (Solomon, 1988, p. 437) intended to sharpen verbal tools and analytical skill *but also* to foster moral virtue.

CONCLUSION

There are, of course, many worries that might be raised for the care orientation in the context of bioethics. Let me look at three that are particularly germane to the present discussion.

It might, first, be objected that there are important moral issues which fall outside the reach of an ethic of care, even if it is caring that leads us to be concerned about them. The worry is that an ethic of care will have nothing to say about certain forms of injustice, that we might, as Virginia Held has put it, "decide that the rich will care for the rich and the poor for the poor, with the gap between them, however unjustifiably wide, remaining what it is" (1987, p. 120). It is important to stress, first, that what is in question in the challenge we have reviewed is not the importance of justice but the sufficiency of justice and the primacy that has been granted the justice orientation in moral theory. An adequate moral theoretical approach may well involve an integration of the justice and care orientations so as to retain their respective strengths through rehabilitated notions of 'justice' and 'care'.

Second, there might be a perceived need for detachment on the part of good physicians and nurses that is incompatible with the emphasis on compassion and sympathy on the care orientation. As Beauchamp and Childress write: "A physician who lacked compassion would generally be viewed as deficient; yet compassion also may cloud judgment and preclude rational and effective responses. Constant contact with suffering can overwhelm and even paralyze a compassionate physician" (1989, p. 383). The important point to make in response to this worry is that there is nothing intrinsic to the care perspective which excludes appropriately detached forms of concern and compassion. A good health care professional should be able to summon the appropriate degree of emotional detachment, or equanimity, when this is crucial to serving the well-being of the patient.

The third difficulty concerns the possible tendency of an ethic of care to allow, on the one hand, too much self-sacrifice on the part of the health care professional, and on the other, overzealous caretaking, leading to too much involvement with patients, or to

paternalism. In response, let me note first that a full account of the virtues of caretaking would need to spell out conceptions of proper self-regard – or care for oneself – as protection against self-effacement or problematic self-denial and as a precondition of sound caring for others (cf. Ruddick, 1984, pp. 217–218; Gilligan, 1982, p. 149). Secondly, it is important, in light of worries about paternalism, to build into our very conception of caretaking the requirement that the caretaker respect the person cared for.⁷ A principal aim of a medical ethics informed by an ethic of care would need to be to address how our institutions and practices of health care can further empower patients and in general encourage more active participation on the part of non-experts in their own health care. This would involve a critical exploration of traditional construals of medical authority and reflection on the effects of power dynamics within ‘healing’ relationships (cf. Warren, 1989, p. 81; May, 1983).

In conclusion, we are still in need of a clear and systematic account of the modes of feeling, of thought, and of action that characterize the care orientation. And we still need to articulate a clear set of standards by which we can distinguish morally good from morally problematic (or even morally debased) forms of ‘care’. We also have a need for boundaries which exclude conceptions of care that serve to justify relations of domination and subordination or which threaten to bolster, rather than to challenge, existing forms of gender division and stratification.

But the strength of the care-oriented approach lies in its most basic recommendation: that we reflect upon the moral voices employed in health care practice and bioethics – the values and ideals that are highlighted, the forms of discourse used, and the models and paradigms that are central to attempts to make sense of medical and moral questions which arise. That challenge urges that we become self-conscious about how the dominant models shape our conception of what morality demands and invites us to question the assumption that there is only one legitimate mode of moral reasoning, only one moral voice. That challenge suggests that part of our job in coming to understand our moral world will involve coming to be reflective about the voices in which we ourselves speak and to listen to and learn from the voices of others. These skills can be made an integral part of a bioethical education.⁸

NOTES

¹ A complex and important question that I cannot go into here is whether and to what extent Kantian and contractarian theories, generally constituting the target of attack in this feminist movement, can accommodate the care orientation. My own position is that they can to some extent, but not fully. Whatever position one takes on this issue, however, one thing remains true: the focus of traditional theories rooted in Kant and the contractarians is quite different from that of the care orientation. I hope that my discussion suggests some ways in which the difference is not one of focus alone.

² This is not to say that all *de facto* relationships are morally acceptable on the care orientation; the care orientation can be understood as striving, among other things, to articulate norms of relationship that more adequately acknowledge the broad facts of human interdependency.

³ Though we must reject the suggestion that there is a distinctive voice that is *woman's as such*, we might understand this recent project in feminist ethics as unveiling – making visible and explicit – in our ethical theories and ethical practices *one* of the important moral orientations emerging out of women's distinctive experiences in our society, given the sexual division of labor and the social significance of gender generally as it affects identity-formation. This project does *not*, however, affirm the care orientation as most appropriate for women; quite the contrary, it affirms its importance in general – for women and men – and thus highlights forms of moral skill and moral maturity that have been overlooked or granted only secondary status in many of our preeminent ethical theories.

⁴ This is not to deny that uncaring people or scoundrels can on occasion show genuine kindness for others. It is to suggest that being concerned about others' well-being, being a kind person, is a condition for having the required sensitivity and sympathetic insight into others that is a further condition of effectively promoting others' well-being in general.

⁵ A notable exception is found in the treatment given the principle of beneficence by Pellegrino and Thomasma (1988).

⁶ William May (1977, 1983) recommends that the relationship between the health care provider and the patient be viewed as a covenant rather than a contract, because it lacks a specific *quid pro quo*. Warren Reich (1987) argues that contract models and rights language are "too adversarial" and fail adequately to capture the need for "acceptance, trust, affection, and care" which can in effect constitute the moral status of others within relationships. He emphasizes the need to encourage bonding and loyalty to those in need of care, not just respect for rights. Pellegrino and Thomasma (1988) explore the limitations of contractual models of relationship in medical ethics, stressing the unequal power and vulnerability introduced through illness. Annette Baier (1986) recommends that a language of trust and anti-trust be introduced into our ethical reflections to supplement if not supplant contract models. All of these proposals and others might be critically evaluated and contrasted with standard contractual models.

⁷ Pellegrino and Thomasma (1988) develop an account of beneficence which invokes, as an integral part, respect for the autonomy of the one whose good is served.

⁸ An early version of this paper was first presented in the Intensive Bioethics Course at the Kennedy Institute of ethics at Georgetown University in June 1989. I am grateful to those present in the audience for their challenging questions. In addition, I am especially indebted to Tom Beauchamp's helpful comments and suggestions on an earlier draft of this paper.

BIBLIOGRAPHY

- Baier, A.: 1986, 'Trust and antitrust', *Ethics* 96, 231–260.
- Baier, A.: 1987a, 'The need for more than justice', in M. Hanen and K. Nielsen (eds.), *Science, Morality and Feminist Theory*, Supplementary Volume 13 of *Canadian Journal of Philosophy*, pp. 41–56.
- Baier, A.: 1987b, 'Hume, the women's moral theorist?' in E. Feder Kittay and D.T. Meyers (eds.), *Women and Moral Theory*, Rowman and Littlefield Publishers, Totawa, New Jersey, pp. 37–55.
- Beauchamp, T.L. and Childress, J.F.: 1989, *Principles of Biomedical Ethics*, 3rd edition, Oxford University Press, New York, New York.
- Beauchamp, T.L. and McCullough, L.B.: 1984, *Medical Ethics: The Moral Responsibilities of Physicians*, Prentice-Hall, Englewood Cliffs, New Jersey.
- Benhabib, S.: 1987, 'The generalized and the concrete other: The Kohlberg-Gilligan controversy and moral theory', in E. Feder Kittay and D.T. Meyers (eds.), *Women and Moral Theory*, Rowman and Littlefield Publishers, Totawa, New Jersey, pp. 154–177.
- Bishop, S.: 1987, 'Connections and guilt', *Hypatia* 2 (1), 7–23.
- Blum, L.: 1980, *Friendship, Altruism, and Morality*, Routledge and Kegan Paul, Boston, Massachusetts.
- Faden, R.R. and Beauchamp, T.L.: 1986, *A History and Theory of Informed Consent*, Oxford University Press, New York, New York.
- Friedman, M.: 1987, 'Beyond caring: The de-moralization of gender', in M. Hanen and K. Nielsen (eds.), *Supplemental Volume 13 of Canadian Journal of Philosophy*, pp. 87–110.
- Gilligan, C.: 1982, *In a Different Voice: Psychological Theory and Women's Development*, Harvard University Press, Cambridge, Massachusetts.
- Gilligan, C.: 1984, 'The conquistador and the dark continent: Reflections on the psychology of love', *Daedalus* 113, 75–95.
- Gilligan, C.: 1987, 'Moral orientation and moral development', in E. Feder Kittay and D.T. Meyers (eds.), *Women and Moral Theory*, Rowman and Littlefield Publishers, Totawa, New Jersey, pp. 19–33.
- Gilligan, C., Ward, J. and Taylor, J. (eds.): 1988, *Mapping the Moral Domain*, Harvard University Press, Cambridge, Massachusetts.
- Held, V.: 1987, 'Feminism and moral theory', in E. Feder Kittay and D.T. Meyers

- (eds.), *Women and Moral Theory*, Rowman and Littlefield Publishers, Totawa, New Jersey, pp. 111–128.
- Hill, T.E., jr.: 'The importance of autonomy', in E. Feder Kittay and D.T. Meyers (eds.), *Women and Moral Theory*, Rowman and Littlefield Publishers, Totawa, New Jersey, pp. 129–138.
- Kohlberg, L.: 1981, *The Philosophy of Moral Development: Moral Stages and the Idea of Justice: Essays on Moral Development, 1*, Harper and Row, San Francisco, California.
- Kohlberg, L.: 1984, *The Psychology of Moral Development: Essays on Moral Development, 2*, Harper and Row, San Francisco, California.
- May, W.: 1977, 'Code and covenant or philanthropy and contract?' in S.J. Reiser, A.J. Dyck, and W.J. Curran (eds.) *Ethics in Medicine*, MIT Press, Cambridge, Massachusetts, pp. 65–76.
- May, W.: 1983, *The Physician's Covenant: Images of the Healer in Medical Ethics*, Westminster Press, Philadelphia, Pennsylvania.
- McDowell, J.: 1979, 'Virtue and reason', *The Monist* 62, 331–351.
- McKeon, R. (trans.): 1941, *The Basic Works of Aristotle*, Random House, New York, New York.
- Murdoch, I.: 1970, *The Sovereignty of Good*, Routledge and Kegan Paul, London, England.
- Nussbaum, M.: 1985, 'The discernment of perception: An aristotelian conception of private and public rationality', *Proceedings of the Boston Area Colloquium in Ancient Philosophy* 1, 151–207.
- Overall, C.: 1987, 'Surrogate motherhood', in M. Hanen and K. Nielsen (eds.), *Science, Morality, and Feminist Theory*, Supplemental Volume 13 of *Canadian Journal of Philosophy*, pp. 285–305.
- Overall, C.: 1989, 'The politics of communities', *Hypatia* 4(2), 179–185.
- Pellegrino, E. and Thomasma, D.C.: 1988, *For the Patient's Good*, Oxford University Press, New York, New York.
- Piaget, J.: 1932, *The Moral Judgment of the Child*, Free Press, New York, New York.
- Rawls, J.: 1971, *A Theory of Justice*, The Belknap Press of Harvard University, Cambridge, Massachusetts.
- Reich, W.T.: 1987, 'Caring for life in the first of it: Moral paradigms for perinatal and neonatal ethics', *Seminars in Perinatology* 11, 279–287.
- Ross, W.D.: 1930, *The Right and the Good*, Clarendon Press, Oxford, England.
- Ruddick, S.: 1984, 'Maternal thinking', in J. Trebilcock (ed.), *Mothering*, Rowman and Allanheld, Totawa, New Jersey, pp. 213–230.
- Ruddick, S.: 1989, *Maternal Thinking*, Beacon Press, Boston, Massachusetts.
- Sher, G.: 1987, 'Other voices, other rooms? Women's psychology and moral theory', in E. Feder Kittay and D.T. Meyers (eds.) *Women and Moral Theory*, Rowman and Littlefield, Publishers, Totawa, New Jersey, pp. 178–189.
- Sherman, N.: 1990a (in press), 'The place of emotions in kantian morality', in O. Flanagan and A.O. Rorty (eds.), *Identity, Character, and Morality*, MIT Press, Cambridge, Massachusetts.

- Sherman, N.: 1990b (unpublished manuscript), 'The place of emotions in morality'.
- Sherwin, S.: 1987, 'Feminist ethics and *in vitro* fertilization', in M. Hanen and K. Nielsen (eds.), *Science, Morality, and Feminist Theory*, Supplemental Volume 13 of *Canadian Journal of Philosophy*, pp. 265–284.
- Sherwin, S.: 1989, 'Feminist and medical ethics: Two different approaches to contextual ethics', *Hypatia* 4(2), 57–72.
- Solomon, D.: 1988, 'Internal objections to virtue ethics', in P. French, T.E. Uehling, jr., and H.K. Wettstein (eds.), *Midwest Studies in Philosophy Volume XIII: Ethical Theory: Character and Virtue*, University of Notre Dame Press, Notre Dame, Indiana, pp. 428–441.
- Warren, V.L.: 1989, 'Feminist directions in medical ethics', *Hypatia*, 4 (2), 73–87.
- Winslow, G.: 1984, 'From loyalty to advocacy: A new metaphor for nursing' in T.L. Beauchamp and L. Walters (eds.), *Contemporary Issues in Bioethics*, Wadsworth Publishing Company, Belmont, California, pp. 323–333.