Three versions of an ethics of care

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Abstract   The ethics of care still appeals to many in spite of penetrating criticisms of it which have been presented over the past 15 years or so. This paper tries to offer an explanation for this, and then to critically engage with three versions of an ethics of care. The explanation consists firstly in the close affinities between nursing and care. The three versions identified below are by Gilligan (1982), a second by Tronto (1993), and a third by Gastmans (2006), see also Little (1998). Each version is described and then subjected to criticism. It is concluded that where the ethics of care is presented in a distinctive way, it is at its least plausible; where it is stated in more plausible forms, it is not sufficiently distinct from nor superior to at least one other common approach to nursing ethics, namely the much-maligned 'four principles' approach. What is added by this paper to what is already known: as the article tries to explain, in spite of its being subjected to sustained criticism the ethics of care retains its appeal to many scholars. The paper tries to explain why, partly by distinguishing three different versions of an ethics of care. It is also shown that all three versions are beset with problems the least serious of which is distinctiveness from other approaches to moral problems in health care.

Keywords: ethics of care, Gilligan, Tronto, Gastmans, Little.

Introduction

In spite of telling criticism (Allmark, 1995; Kuhse, 1997; Paley, 2006) the ethics of care retains its appeal

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to many scholars within nursing and beyond (Tronto, 1993; Gastmans, 2006; Hewitt & Edwards 2006; Griffiths, 2008). There are historical reasons for its popularity in nursing. These stem from a line of thought according to which while 'curing' defines medicine, 'caring' defines nursing (cf. Liaschenko & Davis, 1991). As the two disciplines were defined in these terms, it was believed to be plausible by many that while an ethics of principles was appropriate for medicine and its practice, an ethics of care was most

appropriate for nursing and its practice. This emphasis on an ethics of care was fuelled even further by the fact that in its early versions, a gendered element was present within the ethics of care such that it is an approach to ethics associated with females as opposed to males. This sat well with perceived gender distributions stereotypically associated with medicine and nursing according to which medicine is male dominated and nursing female dominated. Thus we find that Fry writes of principle-based approaches to ethics that they 'espouse a masculine approach to moral decision making and ethical analysis' (Fry, 1989, p. 93), the implication being that this thereby renders them inappropriate for application to the nursing context.

As mentioned, in spite of the criticism to which ethics of care has been subjected, its appeal remains. Part of the explanation of this stems from the vagueness of an ethics of care about which many commentators and critics have complained. But a further explanation for the continued appeal of the ethics of care stems from the fact that since the early work done by Gilligan (1982) and Noddings (1984), subsequent commentators have produced versions of an ethics of care which differ significantly from the earliest versions of it. Because of this, it is now plausible to think of ethics of care in terms of three broad types. I take these to be represented by the work of Gilligan (1982); Tronto (1993); Gastmans (2006); also Little (1998).

Version 1: Gilligan (1982)

As Gilligan's presentation of an ethics of care has been described many times, I will not spend much time doing so. Roughly, Gilligan's idea is that it is possible to identify two different approaches to moral problems. One approach is described as an 'ethics of justice' and another, an 'ethics of care'. In an ethics of justice moral problems are approached in the same way in which other kinds of problems are approached: they are analysed, competing principles are weighed up, and a conclusion drawn. Cool, impartial deliberation is the prevailing feature employing abstract moral principles, such as 'do not steal', and 'protect human life'. In a situation in which there is a

clash between these, the person adopting the ethics of justice works out which is the most weighty and acts accordingly.

By contrast, in an ethics of care, one focuses 'further in' on the problem as opposed to 'abstracting out' relevant moral principles. Thus one considers contextual factors such as the nature of the relationships between those involved in the problem. One seeks to preserve these relationships and to engage with their emotional registers.

Critics have complained about the lack of clarity in the core concept of an ethics of care, namely care itself. Several commentators (e.g. Allmark, 1995; de Raeve, 1996; Paley 2006) point out that the term can be used, perfectly properly, in a way which implies little emotional attachment, e.g. one might agree to care for one's neighbour's cat while she is away, or water her plants. One might do this but have no emotional attachment to the cat or to the plants. Similarly, a nurse might care for patients in this sense, in which 'Alex cares for x' means little more than that Alex looks after x – be x his patients, his neighbour's cat or his neighbour's plants – in the absence of any emotional connection with x. A further sense of care identified by commentators is that in which, in contrast to the sense just identified, its use does signify emotional involvement with that which is cared for. Hence, this is the sense of 'care' which is likely to characterize one's relationship to those closest to one. And of course, one might say the same of a nurse who is especially caring, in this sense, towards his patients.

It might be maintained that this ambiguity is not fatal in any way to an ethics of care. Suppose this is accepted, at least two further problems remain, each of which seems serious. The first is that, as Allmark has explained, in order for an action or mental state to be morally defensible more is needed than that the mental state or action stems from care (Allmark 1995, p. 23). To illustrate this point, it is feasible to suppose that a parent wakes his 10-year old son up at 05:00 h every morning and compels the child to go through a punishing fitness programme, which always terminates with a cold bath. The parent genuinely claims to be acting in the best interests of the child and to be subjecting the child to the fitness regime because he cares so much about his son. Here the parent's mental

states and actions stem from care, care for his son. Yet, plainly it does not follow from this that they are ethically defensible. Many other parents might think the parent is cruel, rather than caring. This example shows that the fact that an action or a mental state is characterized by care is not sufficient for either to be ethically defensible. To quote Allmark: 'what we care about is morally important, the fact that we care *per se* is not' (Allmark 1995, p. 23).

The second problem is that the ethics of care, in this first manifestation, seems to eschew commitment to a formal principle of justice according to which 'equals should be treated equally and unequals unequally' (Beauchamp & Childress, 2009, p. 242). Or as stated by Singer a principle of equal consideration of interests such that 'we give equal weight in our moral deliberations to the like interests of all those affected by our actions' (Singer 1993, p. 21). Although, as proponents of an ethic of care point out, our emotional response would lead us to give priority to the interests of our loved ones, and ourselves, this kind of 'partialism' looks problematic as an approach to ethics. This is because partialism, seemingly arbitrarily, attaches greater weight to the protection of one's own interests above protection of the interests of others – especially those who are moral strangers. Critics complain that no such partialist approach to ethics can be plausible (Kuhse, 1997). To see why, suppose you are a teacher and your daughter is a pupil in the class. You know she has worked hard to prepare for a class exam paper, which you are marking. She needs to pass the exam in order to secure a place in college. You give her a higher mark than she deserves, simply because you care about her – you are seeking to protect and promote her interests. However, of course, to most of us such behaviour would seem unethical. This is because it runs counter to the impartialist constraints on ethical decision making described above. A student whose work was of the same quality as that produced by your daughter but to whom you give a lower mark can claim to be have been treated unfairly – a complaint almost all of us would recognize as legitimate. This shows that impartialism is not an optional extra in approaches to ethics, but is plausibly regarded as an essential element of them. As will be seen shortly, even those very sympathetic to this first

wave of care-based ethics came to recognize this, and abandoned the view that an ethics of care is of a fundamentally different kind than an ethics of justice.

Version 2: Tronto (1993)

As mentioned above, an approach to ethics which jettisons commitment to impartialist constraints on action and distribution such as the principle of justice does not look promising. Some of those persuaded that there is something novel and important in the ethics of care developed a version of it in which justice is not jettisoned. Thus e.g. Tronto states of a plausible version of an ethics of care '. . . a theory of justice is necessary to distinguish among more and less urgent needs' (Tronto, 1993, p. 138). Her clear implication is that in at least some contexts it would not be justifiable to attend to less urgent needs and neglect more urgent needs even if one is emotionally more distant to the person(s) with the more urgent need.

In addition to incorporating a role for justice, Tronto also sees a place for a 'universalist moral principle, such as: one should care for those around one or in one's society' (Tronto, 1993, p. 178). This looks like a further departure from the kind of approach developed by Gilligan as the focus there is against 'universalist principles' and in favour of a more contextualist approach. Also, perhaps in yet further contrast to Gilligan, Tronto tries to develop an ethics of care as a contribution political philosophy. Thus she argues that if we focus on caring relationships and the relationships between power and caring practices, such as bringing up children and caring for the sick, a radically different set of social arrangements will ensue. While the line of thought that Tronto develops in this way is of interest, it would take us too far away from specifically nursing concerns to pursue it here, therefore in the exposition of Tronto's version of an ethics of care I will focus predominantly on its application in the nursing context.

So given that, in apparent contrast to Gilligan, Tronto is explicit that justice must feature in a credible ethics of care, it looks plain that her approach is immune to criticism on that specific point. To start to

describe Tronto's approach, we can begin with the definition of care that she offers:

On the most general level we suggest that caring be viewed *as a species activity that includes everything we do to maintain, continue and repair our 'world' so that we can live in it as well as possible*. That world includes our bodies, our selves and our environment, all of which we seek to interweave in a complex, life-sustaining web.   (Tronto, 1993, p. 103)

In the context of nursing scholarship, readers may well detect some similarities with Benner and Wrubel's work on care in the description of care given in the definition (see Benner & Wrubel, 1989). However, what does need to be said is that the definition looks extraordinarily cumbersome and complicated. This problem is exacerbated as it is conceded by Tronto that 'care consumes much of human activity' but that 'to play, to fulfil a desire, to market a new product or to create a work of art is not to care' (p. 104). This is puzzling as one would think at least that play contributes to our living well, and even 'marketing a new product' might do the same if the product is, say, a product to help clean up polluted water to make it safe to drink. So in common with other commentators who have tried to define care, Tronto's attempt does not get off to a promising start.

However, there are some interesting aspects of Tronto's version of an ethics of care and I will now try to describe these and assess them. The way in which she tries to articulate a distinction related to that which Gilligan draws between ethics and justice, but without neglecting a role of the concept of justice, is to distinguish between what she terms obligation-based ethics, and *responsibility-based* ethics (see also Gilligan, 1982, pp. 73–74). Traditional approaches to ethics, it is claimed, are obligation based. Thus, the suggestion is, in moral decision making when considered from the perspectives of utilitarianism, deontology or Beauchamp and Childress's 'four principles' approach (Beauchamp & Childress, 2009), the decision maker works out what obligations, if any, they might have to respond to a situation and then responds accordingly. Such a position is underpinned by an ontology of the person such that humans are typically separate, independently living, autonomous beings defined in terms of their own, autonomously chosen, moral projects.

By contrast, in responsibility-based ethics the initial starting point of the human is relational involvement with others. The difference this makes in terms of the moral domain is that one's 'starting point' so to speak is one of involvement with others rather than separation from them. And so, the corresponding moral presupposition is responsibility for others. So if one witnesses or hears of another's misfortune one's initial disposition is one of responding to the plight of the other person. Instead of asking, 'what, if any, obligations do I have to help that person? One asks 'How can I help?' one asks this because one is already involved with them, and not separate from them.

To express Tronto's distinction slightly differently, in responsibility-based ethics there is claimed to be a pre-existing moral relationship between people, and so responding to their plight is 'automatic' not in need of justification. But in obligation-based ethics, because one's initial relationship with others is separation, not involvement, one will only respond if one recognizes an obligation to do so. So in obligation-based approaches, responding to others involves a 'two-stage' process, a first in which one is made aware of the plight of another person, and a second in which one deliberates over which obligations one has towards them – if any. But in responsibility-based approaches, the awareness and the disposition to respond are combined. Hence, Tronto states that an ethic of care involves 'a habit of mind to care' (Tronto, 1993, p. 127), not simply to be emotionally moved by the plight of others but to be orientated to help them too. To quote Tronto again: 'The moral question an ethic of care takes as central is not – What if anything do I (we) owe to others? but rather – How can I (we) best meet my (our) caring responsibilities' (Tronto, 1993, p. 137).

That distinction is helpful to signal what is novel in Tronto's approach. But obviously further detail needs to be added to the point about the basic ethical orientation. In addition to what she says about that, Tronto goes on to explain that she conceives of an ethics of care as a practice. Thus she writes:

Care is . . . best thought of as a practice [which involves] . . . both thought and action, that thought and action are interrelated, and . . . are directed to some end. (Tronto, 1993, p. 108; cf. van Hooft, 1995)

As part of this practice, Tronto proposes 'Four phases of caring' (Tronto, 1993, p. 105) and also 'Four elements of care' (Tronto, 1993, p. 127).

The four phases of care are caring about, taking care of, caregiving and care receiving. Caring about involves 'noting the existence of a need and making an assessment that this need should be met' (Tronto, 1993, p. 106). So, in the nursing context one might see that a patient is uncomfortable and conclude that they have a need which should be met. Beyond the nursing context, one might be made aware of the plight of people in a disaster-struck country and come to the view that they have a need which must be met.

'Taking care of' involves 'assuming some responsibility for the identified need and determining how to respond to it' (Tronto, 1993, p. 106). So, to continue with the previous examples, the nurse in our previous example might work out which is the best way to respond to the patient in discomfort, similarly in the situation regarding responding to people in a disaster-struck country.

With regard to 'care giving', as might be expected Tronto describes this in terms of the 'hands on' work of responding to people's needs. Thus, in our examples this would involve the nurse, e.g. making the patient comfortable, and, perhaps, by the person taking some action to help the people in the stricken country.

The last of these 'phases' of care 'recognizes that the object of care will be affected by the care it receives' (Tronto, 1993, p. 107). The examples Tronto provides of this are of a piano responding to having been retuned, a patient feeling better (e.g. more comfortable) and a child feeling better after having been fed.

It seems reasonable to suppose that the choice of the term 'phase' by Tronto signals temporal ordering, such that the phases are gone through in sequence, though of course, as she makes plain, they overlap in part.

What then, of the four elements of care? The first of these is attentiveness, which involves the 'recognition of a need and that there is a need that be cared about' (Tronto, 1993, p. 107). As she explains, fostering this attentiveness is important to try to ensure that people are not neglected – are cared for. Tronto also reminds us of the way in which being insufficiently attentive can be a moral failing. Thus suppose a nurse walks past a patient who looks to be in severe distress; the nurse simply fails to notice this in the face of the patient. That would be one example of the kind of moral failing – and perhaps professional failing also – to which Tronto is pointing and which brings out the significance of attentiveness in the moral domain.

The second element she identifies is that of 'responsibility' (Tronto, 1993, p. 107). I have discussed above the way in which this concept is used by Tronto to try to distinguish care-based from 'obligation-based' approaches to ethics. The part responsibility plays as one of these elements of care is slightly unclear to me. However, she does say this:

Ultimately, responsibility to care might rest on a number of factors; something we did or did not do has contributed to the need for care, and so we must care. (Tronto, 1993, p. 132)

She gives parenting a child as an example of what would count as something one did which created a need for care and so to which one would have caring responsibilities. But she also mentions responsibilities when one does not have any direct causal role in the creation of a need for care – as e.g. might arise when one responds to an appeal for aid for people in a poor country. (Tronto's example is that responsibility adopted by some people under the reign of the Nazis in Germany to try to help Jewish people (Tronto, 1993, p. 132)) However, for our purposes here we can accept that if anything is true, it is true that nurses have responsibility for those in their care. So in the context of nursing ethics there need be no ambiguity concerning that specific point. It is possible to pose some awkward, if familiar questions of course to complicate matters, such as the scope and extent of those obligations, but let us set these aside.

The third element of an ethics of care is ostensibly more straightforward, this is competence (Tronto, 1993, p. 133). The proposal here is that when care is

given it should be executed competently, to do so incompetently is a failure of care. The inclusion of this element reinforces the point that an ethics of care, as Tronto sees it, involves more than simply the experience of an affective state, it involves actions too. In her elaboration of what competence in care amounts to, she discusses briefly an issue of professional ethics which is of direct relevance to nursing. The example she gives is of a school teacher who is instructed to teach mathematics even though he has no training in that subject. The school governors, meanwhile, congratulate themselves on having dealt with a problem in fulfilling their obligations to ensure their pupils have maths lessons. She observes 'Especially in large bureaucracies, this type of 'taking care of' with no concern about outcome or end result seems pervasive' (Tronto, 1993, p. 134). In the nursing context, an analogous situation would be for administrators to allocate insufficient numbers of nursing staff to care for patients in a particular unit or ward. Thus, the responsibility of the administrators is not fulfilled if staffing levels are such that competent care is impossible. The same applies to the nurses themselves of course. They have a responsibility to try to deal with the problem to ensure conditions for provision of competent care can be obtained.

The final ethical element of care is that of 'the responsiveness of the care receiver to the care' (Tronto, 1993, p. 134). The main focus of Tronto's explanation of this last element, though, concerns the idea of vulnerability. She suggests that when we are in need of care we are reminded of our own vulnerability. Moreover, she points to the dangers of being too caring, and thus of creating dependencies on the carer by the person being cared for. Hence, Tronto writes 'The moral precept of responsiveness requires that we remain alert to the possibilities for abuse that arise with vulnerability' (Tronto, 1993, p. 135). This is something which is especially pertinent to the nursing context of course, in which nurses are caring for people who are often dependent and vulnerable to a high degree.

After describing these four elements, Tronto states that to care well it is necessary to integrate them all into one's caring acts; that is, to integrate them into the four 'phases' of care. So, in caring about, one is

attentive, in taking care of, one is responsible, in caregiving, one is competent, and in care receiving one is sensitive to the perspective of the care giver.

As readers will have gathered, there are many distinctions made by Tronto and it is quite difficult to assemble them together to gather a clear understanding of what she is getting at, at the specific version of an ethics of care that she is proposing. Nonetheless, here is a crude summary.

At one level, a difference in our disposition to respond to moral problems is posited, this is the difference between the ethics of responsibility and that of obligation. At the next level down, so to speak, there are the four 'phases of care', and then we have the four elements. Moreover, we have the additional complicating factor such that we are to think of care as practice. In nursing contexts, the idea of nursing as a practice in MacIntyre's sense has been widely discussed (Sellman, 2000; Wainwright, 2000). But the primary source for the idea of a practice given by Tronto is Wittgenstein – presumably through his ideas about 'language games' and 'forms of life' (Wittgenstein, 1953) – though she also mentions MacIntyre in a footnote (p. 108). So matters are not quite as straightforward as one would hope. Nonetheless, it is made plain that a practice, minimally, involves 'thought and action directed to some end' (Tronto, 1993, p. 108). So exploiting at least this aspect of a practice should help to explain further how Tronto's approach might apply in the nursing context.

Suppose, then, we try to apply this package to the nursing context to try to spell out this version of ethics of care. This must include the components described by Tronto and hence characterize nursing as a practice in the fairly basic sense she offers; that is, as something which involves, at least, 'thought and action . . . directed to some end' (p. 108). We can think of this as a necessary but not sufficient condition of an activity's being a practice.

First, on the distinction between obligation- and responsibility-based ethics, it is part of the professional responsibilities of a nurse to be responsible for the plight of the patients in her care. It is not an option for a nurse to deny that she is responsible for the patients in her care. So in the specific context of nursing practice, there seems little that is novel here.

Having said that, a qualification is needed. As mentioned above, a major part of Tronto's aims is to articulate an ethics of care which contributes to political theory. So beyond the context of nursing ethics the distinction between obligation- and responsibility-based ethics undoubtedly will have more significance than its proposal within a nursing ethics. Moreover, Tronto's emphasis on caring work, its prevalence, and importance, is also likely to have implications for the 'status' of nursing in the broader social context. However, as a contribution to nursing ethics, there is not much which is new.

A similar complaint arises when we consider the four phases of care. The terms used by Tronto will be very familiar to those who have followed the discussion of ethics of care over the past 20 years or so (see Griffin, 1983; Benner & Wrubel, 1989; Dunlop, 1994; Allmark, 1995; Paley, 2006). We provided examples above of how each of the four phases proposed by Tronto can be exemplified in the context of nursing. Thus when 'caring about' one tries, as a nurse, to be aware of patients' needs. When 'taking care of' one works out the best way to help the patient. When 'care giving' one puts the plan into effect; in a perhaps overly simple example, one makes a patient comfortable, e.g. by repositioning them, or by talking to them, or by some other means. And in the 'care-receiving' phase, if all has gone well the patient will feel better, more comfortable, more reassured, etc.

In addition to the complaint about there not being much new in any of this, one can add a further one. This is that from one perspective associated with an ethics of care, one according to which to care is to be moved in a 'deep', primitive, perhaps non-rational way, Tronto's account looks excessively rationalized. When one sees a frail patient falling out of bed, one instinctively rushes over to try to prevent them from falling or to soften their fall. Thus in such instances the 'taking care of' phase is not a well thought-out plan, but an instinctive response, more akin to a reflex action than to the execution of the conclusion of a plan.

Let us turn now to the four elements of care (attentiveness, responsibility, competence, and responsiveness). These dovetail neatly with the four phases. Thus through being attentive one becomes aware of needs.

By 'taking care of' others we exercise our responsibility to them. In our 'care-giving' we need to do this competently. And in the care-receiving phase, one is sensitive to the complexities of the predicament of the person being cared for.

The close links between the phases and the elements might suggest, though, that the problems which arise at the level of phases are transmitted through to the four elements. Indeed, I think this is the case. Thus it is necessary that nurses are attentive to the needs of their patients and that they cultivate this kind of attention. One way they can do this, as several commentators have noted, is by use of moral imagination (e.g. Scott, 2000). The point about responsibility has already been dealt with. The third element of care is that of competence and it seems plain that there is little to be contended about there. Of course if nurses provide care they should do so only if they are competent to give it: most obviously, one should not give a patient medication by injection if one does not know how to do this safely. With reference to the fourth element, responsiveness, it is of course important that nurses are aware of the vulnerability of their patients, and also of the dangers of caring for them too much, so they become overly dependent upon them. But this, again, is old news (cf. Orem's 'self-care' model of nursing practice (Orem, 1980), and also nursing ethics literature regarding respecting the autonomy of patients (e.g. Benjamin & Curtis, 1992).

In fact, if one tries to state some of the main moral norms which appear to be present in Tronto's ethics of care (to repeat, as applied to the nursing context) they do not sound very distinctive. Consider, e.g. norms such as 'Nurses should be responsible for their patients'; 'Nurses should care for their patients'; 'Nurses should give care competently'; 'Nurses should be morally sensitive to the needs of their patients'. These all seem central to the ethic of care, yet they do not serve to distinguish an ethics of care from other approaches to ethics. Thus e.g. deontological ethical theory might plausibly recast the norms just listed as moral duties, or they may be weaved into a principle-based approach to healthcare ethics of the kind developed by Beauchamp & Childress (2009).

So there are several problems with Tronto's version of an ethics of care. This is the case in spite of the incorporation of a principle of justice. As seen, the distinctive features of it, when interpreted in the nursing context, do not seem to provide a distinctive approach to nursing ethics. So in the light of this, we will turn to discuss, more briefly, a third version of an ethics of care.

Version 3: Gastmans (2006); also Little (1998)

As Gastmans describes this:

I claim that a care ethic stands on its own . . . as a 'moral perspective or orientation' from which ethical theorizing can take place. This will mean that care ethics is more a stance from which we can theorize ethically rather than a full-blown ethical theory in itself.   (Gastmans, 2006, p. 146)

(Cf. Little who also states: 'the care orientation is not a theory; it is a stance from which to do theory' (Little, 1998, p. 204); and van Hooft who states 'caring is seen as an overarching quality that gives action its moral character' (van Hooft, 1999, p. 189).)

It should be said that Gastman's claim is made towards the close of his extremely clear chapter concerning an ethics of care. In support of what seems to be being said in the quoted passage, the claim that there is a general psychological background to caring actions and caring intentions seems a plausible one. An analogy might help to express this more clearly. In contrast to someone who is colour-blind, most of us can see the colours present in the world around us. We can think of moral sensitivity in the same way. Some people, apparently, fail to see the moral dimension of human experience. They are not moved by the suffering of others in the way in which most of us are. Those of us who are so moved can 'see' or otherwise sense, the moral dimension of the world. We have what might be termed 'moral vision' (McNaughton, 1988) and we do not suffer from 'moral blindness'.

With reference to those who have moral vision, some are able to see extremely well – they notice more of the moral aspects of the world – and others less well. We can say that some people have a highly developed moral vision (can see more, morally speaking), than others whose moral vision is less well developed. Strategies such as moral imagination are a useful means of improving moral vision. Some people are moved by the sight of others' suffering and wish to try to help them. It is this kind of moral background – perhaps this is best described as moral psychology (cf. Little, 1998, p. 191) – which is, what seems to me, to be what Gastmans is referring to as his 'moral perspective or orientation'. This makes it possible to experience the moral dimensions of human life, and will hopefully prompt us to act in the right ways when it is appropriate to do so. To go back to something said earlier, the reflex action of trying to stop a frail person from falling, or respond to a child's distress, seems something deep and basic within humans (or at least most of them). If it is this 'backdrop' which is being described as 'care' then, as Gastmans indicates, probably all approaches to moral problems stem from care.

As our discussion of Tronto showed, though, more is needed than simply sensitivity to the moral dimensions of human experience. In order to act morally, we often need some tools to help us respond adequately. By tools it is meant here conceptual tools. As readers will be aware, several such 'tool kits' have been proposed (the moral theories which we have learned of). If I understand Gastmans his recommended 'moral orientation or perspective' is labelled 'care'. What is important to appreciate though, is that (as several critics of an ethics of care have already said) even if care is necessary for proper moral responses, it cannot be sufficient. We need tools, such as those presented by moral theories (including Beauchamp and Childress's principle-based approach) to assist us with our moral problem-solving.

It should be stressed that it is very problematic to determine the precise status of the kind of mental, moral background (or indeed 'orientation') which is being referred to (but see Nortvedt, 2008). Given the possibility of 'moral blindness', such a background can only be a contingent aspect of human psychology. Also, with reference to the kind of 'reflex' response described earlier, when one reacts without thinking to prevent someone from falling, this surely is also subject to cultural conditioning. In an environment where life is cheap, and suffering is rife, such reflexes might be absent. They cannot correctly be regarded as

being wholly insulated from cultural influence and context it seems to me.

So, concerning this third wave of an ethics of care, care is an orientation from which one is prompted to develop adequate responses to moral problems and to the moral dimension of experience. I have emphasized the contingent nature of such a dimension, but for most of us it is simply there, probably due to cultural conditioning. For others, those who have 'moral blindness', it is absent. A third possibility also arises, those who self-consciously develop a 'responsibility-based' outlook – orientation. Thus, following Tronto, one can develop a habit of asking oneself how one can help others as opposed to asking oneself whether or not one has obligations to help them. As noted in criticism of Tronto above, though, this is not necessary in the context of nursing ethics as the norm 'nurses should care for patients' is surely a presupposition of nursing ethics, to which nursing ethics itself tries to develop answers in particular cases, e.g. 'what would be the best way to care for this patient?'

To consider this third version of ethics of care as a nursing ethics, I think it is vulnerable to the same problems which beset Tronto's version when it is applied to the nursing context. This is that a care orientation is simply required in nursing, if by this it is meant the kinds of activities which featured in the elements and phases of caring as described by Tronto. If someone wishes to become a nurse and denies having an orientation to care, it would be reasonable to ask them why they want to do the job in the first place. As suggested earlier, it may even be the case that the moral norm 'nurses should care for patients' is a presupposition of specific approaches to nursing ethics. To see this, imagine an approach to ethics which denied this, and subscribed to the norm 'Nurses should not care for their patients'. If we think of ethics as a normative enterprise, it looks as though the ethics of care states simply that nurses 'should have an orientation to care'. The means by which they manifest this in their moral decision making is left open and that is where work done by other moral theories and approaches is useful to structure one's intuitions – i.e. the moral principles, duties, rights, consequences and so on.

Conclusion

So, to summarize, it is evident that an ethics of care is still attractive to nurse scholars in spite of criticism which now stretches back several years (Allmark, 1995; Kuhse, 1997). The close connection between nursing and care is surely at least part of the explanation for the continued appeal of an ethics of care to nursing scholars. Also, as described in this paper, the fact that there are radically different versions of an ethics of care complicates matters still further. Having discussed three kinds of ethics of care in the present paper it still seems to me that, in spite of its intuitive appeal the ethics of care is either interesting but implausible, or insufficiently distinct from other more well-known approaches to moral problems in nursing, e.g. the four principles approach.

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