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Justice and Proximity: Problems for an Ethics of Care

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Abstract This paper aims at addressing some questions considering the conflicting normative claims of partiality, i.e. to provide for the caring needs of the particular patient, and impartial claims of treating all patients with a relevant need equally. This ethical conflict between different conceptions of moral responsibilities within professional ethics relates to debates between an ethics of care and an ethics of justice. An ethics of care is a particularistic position that endorses some form of partiality, i.e. favouring persons to whom one stands in particular relationships. This paper argues that also a professional ethics must endorse some kind of partiality at the clinical level of health care. In fact, consideration of care for particular patients is a prerequisite for giving proper and attentive care towards the individual patient. This paper will discuss how partial concerns might be balanced against claims of distributive justice within the frame of the formal principle of justice. It is concluded that there is an urgent need for the recognition of the consequences of macro-level decisions for the possibility of the discharge of moral responsibility on a clinical level of health care. This would mean that health care institutions should adapt for the possibility of a basic standard of proper care and attention for the individual patient.

Keywords Ethics of care · Partiality · Professional ethics · Health care · Formal principle of justice

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Introduction

How to reconcile qualified concerns for the particular individual patient with claims of equal concerns and maximisation of health related welfare for all is a pressing issue in today's health care. There is a growing tendency that qualified attention to the individual patient suffers and amplifies an imbalance between concerns of relational and individual care and concerns of distributive justice. Recent studies into health care prioritisation in Norway and also international studies indicate that individual and relational aspects of care are under severe strain in contemporary health care [5, 17, 19, 24, 25]. This is a burning ethical question since illness and hospitalisation are sources of particular vulnerabilities [24] and since lack of proper relational care and concern can result in increased suffering for the patient [20]. It is a problem for professional health care ethics because conflicting moral claims impinge on the health care worker in daily practice. These problems can be illustrated by means of an example.

Tom is a nurse who works in a nursing home ward containing 25 beds, where 10 out of these beds are for short term stay. Lack of resources, such as time, budget cuts, and shortages of personnel with regard to the needs of nursing care, coupled with claims of efficiency and utility maximisation of the short term beds, had for a long time influenced the ability to provide proper and high-quality care for the individual patients at the ward. The day shift this Tuesday was a rather typical one. The ward was short-staffed, and two of the short-term patients were to be discharged early in the morning to make the rooms ready for new patients. Tom knew he had to give priority to the most basic needs of all of his patients and make sure that the discharged patients left early. Because of this, Tom felt he was unable to give the patients of whom he was particularly responsible important basic care and support. He was not able to provide time for information and communication with the patients who were to be discharged. One of these patients, Mary, was very anxious about leaving since she lived alone and her family was away on a holiday trip. Tom's professional assessment was that Mary's physical state and self-care could improve greatly if she only could have stayed one more week. But he also knew that if the stay was extended, another patient would suffer. Tom did also have to give less priority to the morning toilet of the frailest patients, and two of the patients had to stay in bed in order for him to provide a minimum of nursing care for all patients at the ward.

As we see, Tom had to make priority decisions with regard to the caring needs of particular patients at the ward. He also had to balance his professional tasks and responsibilities between individual and proper care for the patients at the ward and the universal considerations for the caring needs of other unknown patients waiting for admission to the ward. These ethical conflicts exemplified here can be illustrated in light of current debates about an ethics of care and an ethics of justice. These two ethical perspectives mutually restrict one another in a fundamental way. An ethics of justice takes ethical decisions to be based upon universal principles and rules, and in an impartial and verifiable manner to ensure the fair and equitable treatment of all people [3]. An ethics of care, on the other hand, emphasises the compelling moral salience of attending to and meeting the needs of the particular others for whom we

take responsibility [9]. According to the care perspective, responding to the needs of a dependent and particular other person is independent of universal principles and rules.

Our main concern in this paper is how the normative potential of an ethics of care can inform professional health care ethics. An ethics of care may provide important arguments to the priority of patients to whom the health care professional is relationally close. We will in fact argue that some form and degree of partiality[1] based on relational proximity are of considerable importance for the quality of individualised and professional care-giving. The normative value of relational proximity is independent of any personal or private relationships and bonds, or irrelevant personal preferences between health care personnel and their patients.

The impartial moral values of equality and distributive justice are highly emphasised in health care services in general, as are the ethical ideals of individual concern and attention for particular patients. The main challenge to accept here is how reasons of partiality within contexts of health care can be balanced against impartial claims of distributive and maximising justice. We will approach this difficulty by using the formal principle of justice, which in its form is designed to secure impartiality and consistency in moral deliberations. Hence, if a priority decision has been subjected to an impartial process through this principle, then we should trust that the outcome is not inconsistent with impartial claims of justice. We will discuss the normative implications of applying the notion of 'relational proximity' as a material principle into the formal principle of justice.[2] This means we will try to argue that relationships to particular persons which are close to us in time and space and which we have some form of connection or attachment to in some cases might trump impartiality and can ground unequal treatment. But first there is a need for a brief and rough outline of how the normative claims of an ethics of care are comprehended in this paper.

An Ethics of Care and Partiality in Professional Health Care

An ethics of care is a moral outlook which purports to defend the moral value of relational and individual care, responsibility and responsiveness toward particular other persons within human relationships. The underlying rationale for the valuing of relational and individual care is that it regards human beings as interdependent and vulnerable. In particular, a care ethicist would argue that illness and suffering represent vulnerabilities towards which health care personnel have a professional moral responsibility. It is therefore assumed that an ethics of care also might provide important arguments to the benefit of relational and individual care within role relationships as those between a patient and his nurse or doctor. But then an ethics of care has to come to grip with some deeper structural problems it has a normative

[1] Partiality is here understood as giving higher priority to the caring needs of those patients to whom the health care professional is either relationally or spatiotemporally close, than to those patients to whom the health care professional is not relationally or spatiotemporally close, everything else being equal.

[2] The notions of 'principle of formal justice' and 'material principle' will be explained at page 12.

position. In particular, the care perspective cannot give a satisfactory account of what a person ought to do in cases of conflicting moral claims, as for instance those between care for particular persons and impartial justice [15]. An ethics of care emphasises the importance of equal concern for the interests and needs of every affected person in a morally difficult situation, and the harmonising and balancing of these interests and needs [6]. By the concept of mature care it is also stressed that the interests and needs of the moral agent should be taken into account in this balancing [21]. But an ethics of care seems normatively inadequate in cases where it for some reasons are impossible or very difficult to harmonise the interests and needs of every affected party. This could be the case in situations where the interests or needs in question are very divergent but still of equal significant moral value. In health care ethics, one typical example of such a dilemma is cases where scarcity of necessary resources, such as time and personnel, makes it impossible to harmonise the interests and needs of all.

It is therefore important to note that an ethics of care also might be considered a particularistic position approving a certain form of partiality. The problem is that the position has almost exclusively debated the legitimacy of favouring relationships within the frame of privacy, family and the like. Care ethicists have never debated the important question about favouring attachment and obligations within role contexts such as between health care worker and patient. In current moral philosophy it has been forcefully argued that a partiality towards family, friends and also a certain group loyalty is permissible [22, 23], but care ethicists have not discussed whether role obligations can be partial, whether a doctor or nurse can give priority to one's actual patient on the basis of care for that particular individual.

For instance, Nortvedt has argued that: "There is an irreducible moral demand born by the confrontation with a particular person's suffering that exceeds any impartial constraints and the obligations one might have to unknown and abstract others. Within the structure of nurse-patient relationships (which is built upon protecting a patient's integrity) lies a moral appeal that makes it unacceptable to accommodate the needs of the other to a set of general and impartial ethical considerations. *Consequently, there is a limit to the de-contextualization and neglect of individual care for the sake of just allocation of resources to others* [14, p. 13]".

So when care ethicists and other moral philosophers advocating partiality and special responsibilities usually plead their cause by referring to its valuable contribution to the personal relationship as those between a mother and a child, between friends, and between husband and wife, the relevance for role-obligations are more problematic. A professional relationship is in an important sense of a different nature than the attachments and loyalties within personal relationships. Health care professionals are not bound by special responsibilities due to the moral worth of a relationship per se. Traditional arguments considering partiality within the personal sphere are therefore not easily applicable to professional relationships. In particular, there are two important differences between personal relationships and professional relationships that need consideration. Firstly, as a contrast to personal relationships, professional relationships are structured role relationships where the professional roles are defined prior to the establishment of the relationship. That is, the existence of a professional relationship is dependent on the predefinition and

establishment of the relevant roles in question, for instance a nurse and a patient. A patient does not, at least ordinarily, seek professional health care workers for other reasons than their medical or caring needs. Instead, the patient-professional relationship is focused on a particular good which both parties wish—or usually wish—to promote [11]. It is also essential that the professional relationship is asymmetrical in different sense than many caring relationships in the private domain. The professional has knowledge and competence that the patient or recipient of health care lacks. This knowledge and competence is of fundamental importance for the patient, and the asymmetry in knowledge and competency also represent critical asymmetry in power and vulnerability. This latter point also relates to the second important difference between personal and professional relationships. This concerns the nature of a professional's ethical obligations to patients which is restricted by ethical guidelines giving emphasis to impartiality and equality. In health care, moral responsibilities are framed by the distinctive areas of professional concerns, such as medical needs or special needs of nursing care. The particular areas of professional responsibilities are directed to any person in need of professional health care. Subsequently, when one assumes the role of a professional health care worker, certain impartial and general obligations and responsibilities follow. These role obligations and responsibilities are general ones because they apply to any occupant of the profession in question. However, the proper performance of one's professional role in concrete situations may involve particularistic and agent-relative[3] considerations [2, 18]. Decisions and actions taken from these obligations and responsibilities depend to some degree on the individual professional's understanding of the values and ideals that inform the profession in question (Blum, ibid.). This does not entail subjectivism since "arguments can be given for the superiority of at least some interpretations over others, and some interpretations can be ruled out as too far from what any reasonable person could take the ideals and values of a particular profession to entail (Blum, ibid., p. 105)". It is rather the case as Applbaum puts it: "The professions characteristically put forth *role-relative* but *person-neutral* prescriptions [1, p. 64]". Concrete actions stemming from one's understanding of the values involved in caring for the particular patient with his medical needs and his needs of nursing care, cannot be explained nor justified exclusively in terms of general and impartial reasons. For instance Oakley et al. have discussed the inadequacy of utilitarian and Kantian approaches to professional ethics "(…)an approach which judges the legitimacy of all professional behaviour directly in terms of broad-based moral standards will not do justice to the responsibilities and sensitivities proper to various professional roles, and that a satisfactory ethic for a given profession must

[3] Agent-relative concerns are opposed to agent-neutral concerns, and are moral concerns that are related to the moral participant, his/her preferences, desires, and obligations. Agent-neutrality is most frequently explained in terms of agent-neutral reasons. Agent-neutral reasons can be described as follows: "If a reason can be given a general form which does not include an essential reference to the person who has it, it is an agent-neutral reason. For example, if it is a reason for anyone to do or want something that it would reduce the amount of wretchedness in the world, then that is a neutral reason" [12, pp. 152–153]. Agent neutrality is therefore an important aspect for impartiality, whereas agent relativity might provide reasons for particularism and partiality.

be able to recognise the particular roles, responsibilities, and sensitivities appropriate to that profession (ibid., pp. 2–3)". It is a fact that a competent and professional comprehension of the particular caring needs of a patient is dependent on human closeness. The performance of a medical procedure, caring for a bed wound, and the process of informing a patient or giving comfort and consolation, are all activities that happen face to face, in bodily and human interaction. Hence, relational proximity to the person in need has fundamental importance for giving attentive and proper medical and nursing care. Giving attentive and proper medical and nursing care is a fundamental good that health care professions are supposed to serve and which requires opportunity for allocating adequate time and disposable personnel. Partiality towards the medical and nursing needs of the patient relationally close to the professional might therefore be a prerequisite for rendering possible the professional's responsibilities.

Partiality within professional conduct of care often exhibits a direct, altruistic concern for a particular patient based on his or her particular needs and human condition in the actual situation. It might be a here-and-now situation, and it is based on, and necessitates a face-to-face encounter between the patient and the professional. Though we make use of the notion 'relational proximity' in this paper, it is important to note that this notion is understood in different ways dependent on the clinical setting and situation, and also with respect to different specialisations as well as the workplace of the professional. Still, these different meanings are of equal significance for the argumentation, and it is our claim that both have equal potential for giving rise to special moral responsibilities. One meaning of the term relational proximity denotes closeness in time and space as a particular feature of inducing moral responsibilities. Among many examples of clinical relevancy here are emergency wards and surgical wards where the patients are admitted for a relatively short time. Also, a typical example will be a theatre nurse who only sees the patient for a short time. Here we might have clinical situations where the patient might be unknown, but he is suffering here and now, and his acute human condition is fundamental for responses of human empathy and moral responsibility [16].

A second way of understanding relational proximity is not confined spatio-temporally. Relational proximity might additionally be constituted by particular relational bonds to concrete patients. Relationships between a doctor and a patient or a nurse and a patient, do not have the same structure and emotional characteristics as more intimate and private relations. The former are restricted in time and space, structured by professional role-obligations and lack the emotional temperature and intimate bonding we see in personal relationships. But still relationships with a health care professional can be a *decisive* factor in a patient's struggle to cope with his illness [14]. In elderly care, in long term care, or in rehabilitation care it might be argued that relationships between a professional and a patient have such a special and intrinsic normative value [13, 14]. By intrinsic value we take the relationship to have more than pure instrumental value, for performing a certain task or reaching a special aim, such as for instance relieving pain. Rather, to argue that a relationship has non-instrumental and intrinsic value means that human and personal qualities of the relationship have special significance, i.e. that the professional knows his patient

well, his or her personal history and characteristics, particular psychological needs etc. Professional caring about the patient's particular medical and caring needs imply caring for the patient in his or her totality. Hence, even though professional relationships arise and exist because of particular medical and caring needs, and not because of some personal or private relational bonds, the care-receiver's whole good must be the object of care in both these kinds of relationships (see for instance [2]. Also personal chemistry might play a role within particular settings of care such as in nursing homes and when seriously ill patients are at a hospital ward for a long period.

From this, it also follows, from Scheffler's [22] argument considering the normative value of significant personal relationships, that the non-instrumental valuing of these relationships simultaneously generates a special normative responsibility toward the particular and concrete patient. And, subsequently, the normative challenge that needs to be addressed is how such a patient centred partiality might conflict with the impartial and universal aspirations of professional health care. In what follows we will approach this problem by applying the formal principle of justice.

Relational Proximity and the Formal Principle of Justice

The core element of the formal principle of justice is that it is unjust to treat individuals who are alike in every relevant respect differently, and to treat individuals who are different in some relevant respect alike [4]. The principle aims at justifying equal or unequal treatment in question vis-à-vis others [8]. Since any two patients will differ in *some* respects, and since it is always possible to cite some differences between them to justify differences in the way they are treated (Feinberg, ibid.), an application of the principle is therefore dependent on material criteria which state what should count as relevant differences and similarities in the contexts where it is applied.

From what has been said so far, we will argue that relational proximity in both meanings; giving emphasis to spatio-temporality and empathic responses and personal and emotional ties, constitute an argument for partiality in certain instances of professional health care. A material principle aims at answering a crucial question about distributive justice: "to whom according to what". Subsequently, when applying relational proximity as a material principle, the answer to the question is "to each patient according to the degree of relational proximity".

The line of reasoning is based on relational proximity as a material principle within a particular area. The particular area of concern here is clinical health care. Hence, if we assume that relational proximity can be considered a relevant material criterion for priority decisions at a clinical level, this means that, all things considered, if two (or more) patients have the same need for health care and are equally relationally close to the health care professional, they should be treated equally also with respect to proper medical attention and human care. And, signs reversed, if two (or more) patients are unequal with regard to needs and relational proximity to the health care professional, they should be treated unequally. The

unequal treatment should consist in giving priority (being partial) to the caring needs of the patient(s) who is (are) relationally or spatiotemporally close to the health care professional all other things being equal, i.e. relevant medical needs and caring needs are equal in a relevant way.

Now, one result of applying this principle is that every case in this area is unequal, and every case in this area should therefore be treated unequally. One consequence of applying this principle is that there is a normatively significant difference between the present patient and the unknown patient, and subsequently that the present patient should be treated unequally from a yet unknown and non-admitted patient. The present patient is relationally closer to the professional health care worker, and hence there is a reason for being partial towards the present patient's needs. Recall Tom's dilemma in the example above. The fact that the anxious patient, Mary, is relationally close to Tom, represents a normative significant difference between her and the patient accepted into the ward, but who is yet an unknown. From this difference, it follows that these two patients are to be treated unequally. Tom is then permitted partial concerns and actions towards Mary.

The formal principle of justice is consistent with inequalities in treatment as long as the inequalities are justified by morally relevant features. Beyond its decisive role, the material principle of relational proximity does not restrict the unequal treatment in question, or the degree of partiality. Though 'partiality' does not bring about operational instructions in particular cases where unequal treatment is justified, we think it is sufficient here to say that the substance of the partial acts must be based on professional assessments and judgements in concrete situations This means that the professional acts according to his professional and ethical understanding of the concrete medical or nursing needs of the patient. The concrete acts in question can for instance consist in giving priority to communicating with a patient, or to postpone a morning toilet because the patient needs more rest. In Tom's case, for instance, the partial actions could consist in making time for communication with Mary in the purpose of relieving her anxiety or interacting with her to find a solution of her perceived problems. It could also mean that Tom might be permitted to decide that Mary should stay at the ward for the rest of the day, or even for yet another week to improve her condition. Consequently, unequal treatment might justify partial acts towards some patients at the expense of others.

At a clinical level there will always be impartial claims from other patients that in some cases must trump partiality. An example is when an acute and critical medical situation occurs and one has to prioritise these urgent needs before taking care of the patient(s) toward whom one has a special responsibility. Since it is and must be the particular medical and caring needs of the patients that merits attention, priority decisions are based on professional assessments of these needs. The caring needs of the unknown patient may be more severe than the caring needs of Mary. Therefore, the conclusion drawn above appears problematic. It is therefore important to note that the conclusions above are only legitimate when the relevant medical and/or caring needs of the affected parties are relevantly equal according to a professional assessment of medical and caring needs. This would for instance mean that, if and only if, the need of a short-term stay is what makes Mary and the unknown patient

equal in a relevant and impartial point of view, relational proximity can legitimate partial acts and concerns towards Mary.

At the clinical and individual level, then, where second order priority decisions takes place, this is problematic since partial acts always must be balanced with impartial concerns of other patients with legitimate claims for care. Hence, this also brings up to date fundamental questions of the interaction between first order and second order prioritisation. One of these questions is whether the argument of partiality from a clinical and individual level can trump decisions from an institutional level, based on the impartial principle of equality.

Some of the important questions that arise here are the following: Does unequal treatment permit that the interests of one patient legitimately can be sacrificed to the benefit of other patients? Or does it also imply that the individual patient has some right to protection against the interests of the majority? These exemplifying questions concern both a conception of partiality and a conception of distributive justice. Since relational proximity to the patient has an important role in prioritising (caring) needs at a clinical level, a health care professional is (at least) permitted to prioritise the caring needs of the patient(s) of whom s/he is relationally close. This form of special concern might then legitimately yield the needs of other patients of which the professional is not relationally close. Of course, this is highly challenging from an impartial and consequentialist point of view. One potential response is to say, to follow the insights from Scheffler [22], that special responsibility does not *undermine* the general responsibility towards others. Special responsibility is additional and it increases the total responsibility. And this argument, which we believe is correct, has some serious implications for the way professional responsibility is conceived and how its realisation can and must be arranged. We will return to this in the final remarks.

An interesting question is whether a health care professional only is permitted, or indeed has a moral duty to act partially, and whether all patients have a corresponding right to some special standing. If partiality comprehends a right on behalf of the professional it means that the professional at least has a right to partial acts and concerns. Why should partiality count as a right in this way? As also previously argued, relational proximity is a precondition for realising the professional's moral responsibility of giving attentive and adequate medical and nursing care, it could follow that partial acts and concerns is a prerequisite for fulfilling this professional responsibility. Hence, a simple reason for a right-based and perhaps even a duty-based conception of partiality, is as Jacobs [10] points to, that if health care professionals are not permitted to partial acts and concerns they would be unable to do their job. Now to the question of whether there is any right to a special standing. Some of the core elements in Goodin's [7] theory of responsibility might be a useful supplement to the normative implications drawn from an ethics of care. Goodin points to the great disproportions in power and knowledge when arguing that professionals, especially doctors and lawyers, have "special and especially strong obligations to protect the interests of their clients (ibid., p. 62)". It is important to note here that Goodin's notion of responsibility based on vulnerability is both relational and *relative*. According to his position, the relativity of vulnerability increases the more control a person has over outcomes

that affect another person's interests and the more heavily these interests are at stake in the outcomes. (ibid.). We believe it to be an indisputable fact that patients are indeed vulnerable to the actions and choices of health care professionals. A far more problematic, but not necessarily implausible claim is to say that patients who are relationally close to the professional health care worker are *relatively more* vulnerable to care than are those who are not. This might be so because relational proximity in itself increases the likelihood of being affected by any concern and action involved in the particular caring situation. But at the same time, some may argue, those patients who are not relationally close to the professional might be even more vulnerable, as a result of their helplessness, or their being beyond reach of medical support. This represents a standard objection to partiality from proponents of impartial and consequentialist ethical perspectives, and relates to the debates on distance and proximity in normative ethics in general. The essential point here is that the argument arising from Goodin's position is plausible because it claims that the vulnerability is *relative to the control of the outcomes*. If it is true, which we believe it is, that a health care professional has more control of the outcomes that affect the patient in front of him, than he has over the outcomes that affect a person who is far off or not yet even seen, then an argument based on vulnerability seems plausible.

The individual patient might therefore be said to have a right to some special standing, and it might be a corresponding right of the professional. But the relative desirability of partial acts and concerns must always be an object of professional assessments of the relevant features of the situation.

There is also second, possible implication of applying relational proximity as a material criterion, i.e. to distribute resources to patients according to relational proximity. If the result of applying this principle is that every case in this area is equal, every case in this area must be treated equally. This is the case where two (or more) patients are equally relationally and spatiotemporally close to the professional health care worker, and the medical needs and needs of nursing care are relevantly equal. A problem then arises when scarcity of resources only makes it possible to provide proper and individualised care to only one (or few) of these patients. Hence, even if it might be said that Tom is permitted to act partially towards the needs of Mary, with respect to the other unknown patient, he is not by the same reason permitted to act partial toward her with respect to other patients at the ward. This is so if, and only if, the other patients of concern are equally relationally close to Tom as is Mary. One might reply that this is no genuine problem since Tom then has to give equal consideration to all of them. This would imply, as we saw, to see to it that the most vital needs of both patients are taken care of. But then we are back to square one where qualified and proper care of the individual patient are under severe strain.

A moral dilemma then arises between competing equal responsibilities. Who should be favoured if the moral agent only can help one of two (or more) patients who are equal in the relevant respect? One possible answer is that this depends on the *relative* vulnerability of each patient to the professional. From Goodin's (ibid.) analysis of vulnerability, at least two considerations must be taken into account in moral dilemmas concerning the allocation of responsibilities. When applied to a

health care context, one-first needs to determine how strongly the patient's need would be affected by the alternative actions and choices. This implies a professional assessment of, for instance, severity of the needs, and how (strongly) the needy patients will be affected by the alternative priority decisions. Secondly, one has to determine whether or not the needs of the patient can be taken care of by other health care professionals.

This approach to a resolution of the dilemma might have the possibility of becoming a useful analytical tool for priority decisions at a clinical level. But recall the source of the problems discussed here, which refers to lack of resources such as time and personnel as well as impartial claims of distributive justice. The problems thematised cannot be resolved on an individual and clinical level. Instead, we believe that some of these dilemmas and problems to some degree could and should be reduced by organisational structures and priority decisions at a macro level. Plans and policies on a macro-level must be implemented with a conscious awareness of the consequences for the individual patient [14], and for the health care professional's possibility of discharging the professional and moral responsibility for each individual patient This would mean that health care institutions should adapt for the possibility of a basic standard of proper care and attention for the individual patient. This is of crucial importance for the protection of the individual patient's rights and integrity, and for maintenance of the professional integrity of the health care worker, which constitute the ethical, legal and social responsibilities of professional organisations.

If our analysis of the normative claims of an ethics of care is legitimate in a clinical health care context, then partiality properly understood has important implications on the way we perceive professional moral responsibilities and prioritisations. How to concretely secure a balance between room for proper and individualised care and equal concerns for every patient is a pressing issue for an ethics of care and justice in modern health care [16].

References

1. Applbaum, A. I. (1999). *Ethics for adversaries: The morality of roles in public and professional life*. Princeton, NJ: Princeton University Press.
2. Blum, L. (1994). *Moral perception and particularity*. Cambridge: Cambridge University Press.
3. Botes, A. (2000). A comparison between the ethics of justice and the ethics of care. *Journal of Advanced Nursing, 32*(5), 1071–1075.
4. Feinberg, J. (1973). *Social philosophy*. Englewood Cliffs, N.J.: Prentice-Hall.
5. Førde, R., Pedersen, R., Nortvedt, P., & Aasland, O. G. (2006). Får eldreomsorgen nok ressurser? *Tiddskrift for den Norske Lægeforening, 126*(15), 1913–1916. (Norwegian).
6. Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. London: Harvard University Press.
7. Goodin, R. E. (1985). *Protecting the vulnerable: A reanalysis of our social responsibilities*. Chicago: The University of Chicago Press.
8. Gosepath, S. (2001) Equality. In: *The stanford encyclopedia of philosophy*. http://plato.stanford.edu/entries/equality/.
9. Held, V. (2006). *The ethics of care: Personal*. Political, and Global. New York: Oxford University Press.

10. Jacobs, F. (2005). Reasonable partiality in professional ethics: The moral division of labour. *Ethical Theory & Moral Practice, 8*(1/2), 141–154.
11. Koehn, D. (1994). *The ground of professional ethics*. London: Routledge.
12. Nagel, T. (1986). *The view from Nowhere*. New York: New York University Press.
13. Nordhaug, M. (2004). Mellom omsorgshensyn og fordelingsrettferdighet: sykepleie i et prioriteringsetisk dilemma. (Nursing care and distributive justice—nursing in an ethical dilemma of priority). Master thesis. Oslo: University of Oslo (Norwegian).
14. Nortvedt, P. (1996). *Sensitive judgment: Nursing, moral philosophy and an ethics of c*. Tano Aschehoug: Oslo.
15. Nortvedt, P. (2007). Care, sensitivity and "the moral point of view". In C. Gastmans, K. Dierickx, H. Nys, & P. Schotsmans (Eds.), *New pathways for European bioethics* (pp. 81–97). Antwerpen: Intersentia.
16. Nortvedt, P., & Nordhaug, M. (2008). The principle and problem of proximity in ethics. *Journal of Medical Ethics, 34*, 156–161.
17. Nortvedt, P., Pedersen, R., Grøthe, K. H., Nordhaug, M., Kirkevold, M., Slettebø, Å., et al. (2008). Clinical prioritisations of healthcare for the aged—professional roles. *Journal of Medical Ethics, 34*, 332–335.
18. Oakley, J., & Cocking, D. (2001). *Virtue ethics and professional roles*. New York: Cambridge University Press.
19. Pedersen, R., Nortvedt, P., Nordhaug, M., Slettebø, Å., Grøthe, K. H., Kirkevold, M., et al. (2008). In quest of justice? Clinical prioritisation in healthcare for the aged. *Journal of Medical Ethics, 34*(4), 230–235.
20. Pettersen, T. (2006). Omsorg som etisk teori. *Norsk Filosofisk Tidsskrift, 2*, 151–163. (Norwegian).
21. Pettersen, T. (2008). *Comprehending care: Problems and possibilities in the ethics of care*. Lanham, Md.: Lexington Books.
22. Scheffler, S. (2001). *Boundaries and allegiances: Problems of justice and responsibility in liberal thought*. New York: Oxford University Press.
23. Williams, B. (1973). Consequentialism and integrity. In J. J. C. Smart & B. Williams (Eds.), *Utilitarianism: for and against* (pp. 82–118). Cambridge: Cambridge University Press.
24. Woodward, V. (1999). Achieving moral health care: The challenge of patient partiality. *Nursing Ethics, 6*(5), 390–398.
25. Woolhead, G., Tadd, W., Boix-Ferrer, J. A., Krajcik, S., Schmid-Pfahler, B., Spjuth, B., et al. (2006). "Tu" or "Vous?" A European qualitative study of dignity and communication with older people in health and social care settings. *Patients Education and Counseling, 61*(3), 636–671.