JUSTICE AND CARE: THE IMPLICATIONS OF THE KOHLBERG-GILLIGAN DEBATE FOR MEDICAL ETHICS

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ABSTRACT. Carol Gilligan has identified two orientations to moral understanding; the dominant 'justice orientation' and the under-valued 'care orientation'. Based on her discernment of a 'voice of care', Gilligan challenges the adequacy of a deontological liberal framework for moral development and moral theory. This paper examines how the orientations of justice and care are played out in medical ethical theory. Specifically, I question whether the medical moral domain is adequately described by the norms of impartiality, universality, and equality that characterize the liberal ideal. My analysis of justice-oriented medical ethics, focuses on the libertarian theory of H.T. Engelhardt and the contractarian theory of R.M. Veatch. I suggest that in the work of E.D. Pellegrino and D.C. Thomasma we find not only a more authentic representation of medical morality but also a project that is compatible with the care orientation's emphasis on human need and responsiveness to particular others.

Key words: clinical ethics, deontological liberalism, ethics of care, medical ethics, moral psychology

1. INTRODUCTION

When a student or clinician is introduced to medical ethics, he or she is typically provided with one or more sets and orderings of principles that may be applied to difficult cases; cases presented in such a way that they seem to cry out for some rule to resolve the dilemma they pose. In itself, this approach has already excluded another dimension of ethical concern, what psychologist Carol Gilligan has called the dimension of care [1–3]. Rather than addressing itself to the principled resolution of moral quandaries, the perspective of care highlights the rudimentary moral skills, skills such as kindness, sensitivity, attentiveness, tact, honesty, patience, reliability, etc. that guide us in our relationships with particular others. These two orientations to moral understanding represent what has come to be called the 'justice-care debate'. Although this debate has its original home in the field of moral psychology, its implications have been extended to the fields of moral and political philosophy [4–8], jurisprudence [9, 10], and the natural and social sciences [11–13].[1] In what follows, I will discuss some of the implications of this debate for medical ethical theory.[2]

Theoretical Medicine **13:** 295–318, 1992.

Carol Gilligan's research in moral psychology has provided the impetus for the current reassessment of justice-oriented or principle-driven moral theory [1, 2]. Broadly, Gilligan challenges the adequacy of the deontological liberal construal of moral development offered by Lawrence Kohlberg [17, 18].[3] An extension of Gilligan's insights to medical ethics will likewise challenge the assumption tacitly held by most mainstream medical ethical theories, namely, that the norm of justice provides an adequate framework for representing both the moral dimensions of health care and the moral competencies of health care providers. At the heart of this challenge is Gilligan's identification of another moral orientation that is obscured by the justice perspective. She identifies this orientation as the "perspective of care"; a perspective that enriches the narrow notion of moral competence offered in contemporary moral theory.

2. JUSTICE, CARE AND GENDER

Empirical research has shown that the justice orientation is overrepresented in males and that the care orientation is overrepresented in females [1, 14]. For this reason, the issue of gender is germane to the difference in moral perspective. Further, insofar as the justice perspective, which is the dominant voice in contemporary moral theory, excludes the perspective of care, it fails to give moral credit to or even to address many of the concerns that have historically been associated with women's experience. As Benhabib has pointed out, under the auspices of justice-oriented moral theory, "an entire domain of human activity, namely, nurture, reproduction, love and care, ... the woman's lot in the course of the development of modern, bourgeois society, is excluded from moral and political considerations, and confined to the realm of 'nature'" ([20], p. 160). In short, because nurturing behavior and dispositions to care have been regarded as inescapably 'natural', they have not been credited or encouraged as moral skills.[4]

How may we understand the difference between these two moral perspectives? Briefly, "morality as justice" [17] regards the moral domain as entirely comprehended by the demands of equality, impartiality and universality. The image of justice, blindfolded and holding balanced scales, symbolizes these norms. The care perspective, by contrast, finds moral salience in forms of human relating and responsiveness that arise between human beings who are seen by each other as precisely the *particular* unique human beings whom they are, rather than as abstractly conceived rights bearers. As a result, the care perspective allows for partiality as a legitimate moral point of view. In addition, because the care perspective is attentive to real individuals rather than simply to individuals abstractly conceived, it acknowledges the moral significance of real

inequalities that may in fact distinguish us ([8], pp. 52–53).

Although Gilligan's research discerns different themes in the moral concerns of women and men, it is important to point out that these findings do *not* affirm that there are or should be distinctive women's and men's moralities. Rather than reiterating or reenforcing the archaic notion of separate gender-defined moral realms [23], Gilligan's work shows that an accurate understanding of moral competence must encompass those skills and forms of human relating that have heretofore been neglected or dismissed by contemporary moral theories ([16], p. 25; [24]).

I will give a more comprehensive account of these two moral voices later, but first let me provide some context for the Kohlberg-Gilligan debate.

3. FROM LIBERAL POLITICAL THEORY TO LIBERAL MORAL THEORY: THE PRIORITY OF JUSTICE AS A MORAL IDEAL

The ideal of justice that animates Kohlberg's theory of moral development is grounded in the liberal political theories of Locke, Kant and Rawls ([17], p. 13). Accordingly, Kohlberg's claim that "morality is justice" ([17], p. 166), and that "the fundamental norm of relationship between people is reciprocity and equality" ([17], pp. 54–55), can only be fully understood in terms of the paradigm of liberal citizenship.

As a political theory, liberalism is a rejection of arbitrary and oppressive intrusions by the state into the lives of individuals. In the hierarchical political arrangements of the medieval period to which classical liberalism was a response, a person's political status was based on that person's social or economic position in society. In this way the state, or those powerful individuals in the upper echelons of the hierarchy, could and literally did lord over those who were less powerful by virtue of wealth or position. By contrast, the central assumption of liberalism, both classical and contemporary, is that all individuals are the equal possessors of natural rights or liberties. It is on the basis of these *essential* attributes (rather than any arbitrary social, economic or personal attributes) that individuals have political rights.

In his moral and political writings, Immanuel Kant [25–29] provided crucial philosophical support to the notion of individual liberty. It is the Kantian or deontological strain of liberalism that anchors Kohlberg's theory.

3.1. Kantian Deontology: Autonomy and the Impartial Point of View

For Kant, the individual is autonomous or self-legislating in the sense that he himself[5] creates the moral law through successfully willing the universalization

of his maxims for action. Because he is the author of the moral law, the individual has intrinsic dignity and worth. He may not be used solely as the means to another's end (viz., he is inviolable) because he is an end in himself. Kant's account of moral personality is significant for liberalism because, it "allows us to speak of the dignity and inviolability of every individual and to understand individuals as bearers of rights, simply by virtue of their humanity" ([32], p. 493). In the Kantian scheme, the inviolability of persons entails that the governing principle of association between individuals is respect for autonomy, or respect for persons.[6]

For moral purposes, the Kantian self is a human being whose attributes have been pared down to the moral essence, viz., autonomy. In order that he may arrive at universalizable principles of action, the Kantian moral self or person is construed abstractly as making choices in ignorance of his own particular desires, attachments and attributes. This abstracted self must suppress his variable inclinations and follow duty which, Kant says, is the only thing that can give an action moral worth ([27], p. 28). In this way, the agent's moral judgments are based only on universally applicable rational considerations, rather than on any subjective concern to achieve a particular end ([27], p. 44). It is this abstract conception of the moral agent that guarantees that the moral point of view will be impartial and that no one (including the agent) and no one's interests will be specifically favored or disfavored in moral judgments.[7]

Summarizing the liberal view that originated in the work of Kant and other Enlightenment thinkers, John Hallowell notes that for these theorists,

> the individual human being ... appeared to be the foundation upon which a stable society must be built ... Man as a bare human being, a 'masterless man', appeared to be the solid fact ... Society is made for man, not man for society; it is humanity, as Kant said, that must always be treated as an end and not as a means. The individual is both logically and ethically prior ([36], p. 84).

In other words, to the philosophy of the seventeenth century, societal relationships were regarded as subservient to individuality. From Locke to Nozick, the priority of the individual is one of the fundamental premises of liberal political theory. For in this way, the power and authority of the state is regarded as a function of the individuals who comprise it. The state has no power beyond the consent of the governed.

One of the central difficulties with justice-oriented moral theory, and following from it, justice-oriented medical ethical theory, is that it takes the relationship between the individual and society or the state as the paradigm of moral association and thus extends the constraints governing this association to all other forms of relationship. In short, as Virginia Held explains, the tacit assumption of the justice orientation is "that the public domain is the appropriate locus for the development of moral theory" ([37], p. 112). What critics of justice

theory [1, 2, 8, 20, 22, 38–41] have pointed out, however, is that by regarding the domain of morality in terms of the widest public sphere, justice theories fail to represent the moral bases of particular relationships whose survival depends on more involvement than impartiality and mutual non-interference can secure. These relationships include asymmetrical helping relationships such as those between doctors or nurses and patients and between teachers and students as well as affiliations of intimacy and mutual furtherance such as friendship and family relationships.

In sum, the principles of universalizability, impartiality and autonomy that characterize the Kantian moral viewpoint have been welcomed into liberal theory precisely because they establish the priority of the individual and equal moral status for all. The strength of this view is that by identifying autonomy as *the* morally relevant feature of personality, and therefore, both universality and impartiality as the conditions of moral judgment, this view protects individuals from discrimination on the basis of arbitrary attributes such as social, economic or personal status. However, this narrow construal of the self is also the source of several blindspots in moral theories that are based on the liberal paradigm. First, while an abstract construal of the self necessarily stresses the formal equality that individuals share, it fails to find – and indeed denies – the moral relevance of the material inequalities that actually distinguish us. This oversight shows up not only in Kohlberg's theory of moral development but also in the deontological liberal theories of medical ethics offered by Engelhardt [33] and Veatch [35]. Second, insofar as moral theories construe the self very narrowly as either the source of autonomous willing (as in Kant), or as the locus of utility (as in classical utilitarianism), they make no demands on the development of moral character. The rich notion of moral personality, which includes communicative skills and a sensitivity to circumstances, context, and to particular others is traded for a decontextualized self whose moral resources are necessarily confined to the realm of abstract principle.[8]

4. JUSTICE, CARE AND MORAL PSYCHOLOGY: THE KOHLBERG-GILLIGAN DEBATE

In his cognitive moral psychology, which was inspired by Piaget, Kant and Rawls, Lawrence Kohlberg offers an empirical paradigm for the stages of moral development. Following Piaget's stage theory of cognitive development, the thesis of Kohlberg's research is that moral development too proceeds dialectically through an invariant sequence of stages, the higher stages accessible only after development has been achieved at the lower levels. The sequence of six stages that characterize Kohlberg's developmental scheme was derived from his

research on 72 middle and lower class boys and, Kohlberg argues, is validated by various longitudinal studies [17]. The six stages progress from the premoral level to the conventional level and finally to the level of self-accepted moral principles. The highest stage, that of moral maturity, is characterized by reasoning in accordance with self-chosen ethical principles that conform to the standards of universality and impartiality ([17], pp. 17–19, 409–412). In short, Kohlberg says, there is only "one principled basis for resolving [moral] claims, [and that basis is] justice" ([17], p. 39). Judgments at the sixth stage, the level of moral maturity,

> take the perspective of a moral point of view from which social arrangements derive or on which they are grounded. The perspective is that of any rational individual recognizing the nature of morality or the basic moral premise of respect for other persons as ends, not means ([17], p. 412).

Situating his psychology of moral development within the philosophical tradition Kohlberg says,

> like most deontological moral philosophers since Kant, I define morality in terms of the formal character of a moral judgment ... rather than in terms of its content. These formal characteristics include impersonality, ideality, [and] universality ([17], p. 170).

In an essay entitled "Education for Justice", Kohlberg advocates moral education in keeping with his view of "morality as justice" ([17], pp. 54–55). It is here that he expressly links his deontological theory of moral development with liberalism. Education for justice, he says, "rests on the value postulates of ethical liberalism (Locke, Kant, Rawls). This position rejects traditional standards and value relativism in favor of ethical universals" ([17], p. 73). In sum, Kohlberg maintains that morality is *nothing other* than "justice, the reciprocity between individual and others in the social environment" ([17], pp. 54–55). The morally good person, therefore, "is simply one who reasons with, and acts on the basis of principles of justice as fairness" ([22], p. 623).

In his subsequent 1969 report of a longitudinal study, this time comparing both male and female adolescents and adults [43], Kohlberg notes that while the male population tended to show development to stages four and five on the scale of moral maturity, the female population tended to remain at stage three, the stage characterized by a concern for relationships and trust where "shared feelings, agreements and expectations ... take primacy over individual interests" ([17], p. 410). On the basis of this stage model, therefore, Kohlberg concludes that females are, by and large, immature in their moral reasoning, whereas males display superior moral competency. It was this conclusion that led Carol Gilligan to challenge the accuracy of Kohlberg's theory as a paradigm of moral development. Rather than question women's moral competency when their moral judgments failed to meet the highest standards established by Kohlberg's theory, she challenged the adequacy of the theory itself on both *empirical* and

theoretical grounds.

Gilligan points out that the original experiment from which Kohlberg derived his stage theory was *empirically flawed* because it was based on data gathered from an all male research population. Although Kohlberg's six stages are meant to describe the universal experience of moral development, groups such as girls and women, which were not included in his original sample, rarely reach the higher stages he describes ([1], p. 18). Kohlberg's work is *flawed at the level of theory*, Gilligan argues, because insofar as it is based on insufficiently random data, Kohlberg's ideal of moral maturity (as rational choice of universal moral principles) privileges a singular orientation to moral development. It is this orientation that Gilligan calls the "justice perspective". By so classifying the orientation of Kohlberg's theory, Gilligan's intention is to identify Kohlberg's work as merely one articulation of the broad intellectual tradition that gives primacy to justice as a moral ideal.

The theoretical commitments that underlie the justice orientation can be enumerated as follows. First, because individuals are construed narrowly as generic rights bearers, morally significant relationships (those between such individuals) are characterized by reciprocity and equality. Second, insofar as justice is blind, the moral point of view must be one of impartiality. Third, the commitment to impartiality requires that moral theory as well as moral practice remain indifferent to the specific aims and identities of persons. Fourth, in the service of fairness and impartiality, moral judgment must be principle-driven and dispassionate. Fifth, from the perspective of specifically *deontological* liberalism,[9] impartiality and universality are best served by a theory that imposes no general conception of the good on individuals. For this reason, deontological theory gives priority to the right (the universally agreed-upon procedural principles of morality) over the good, however it is articulated. As we will see, these assumptions disregard many of the features that are distinctive of the healing relationship.

Gilligan was originally led to question Kohlberg's assumptions and conclusions because her own empirical research in moral psychology identified another moral point of view whose normative significance was necessarily obscured by the justice orientation. Gilligan calls this point of view the "care perspective". It falls outside of the limits of justice theory because it emphasizes our moral responsibilities toward those whom we regard not *impartially* (as abstract 'individuals'), but *partially* – as particular individuals with particular relationships, needs and vulnerabilities relative to us. As Flanagan and Jackson point out, whereas the justice perspective

> involves seeing others thinly, as worthy of respect purely by virtue of common humanity, morally good caring requires seeing others thickly, as constituted by their particular human faces, their particular psychological and social self. It also involves taking

seriously, or at least being moved by, one's particular connection to the other ([22], p. 623).

The essential difference, as Gilligan understands it, between a justice and a care perspective is in the different emphases that they place on the dual notions of self and relationship.

> From a justice perspective, the self as a moral agent stands as the figure against a ground of social relationships, judging the conflicting claims of self and others against a standard of equality or equal respect ... From the care perspective, the relationship becomes the figure, defining the self and others. Within the context of relationship, the self as a moral agent perceives and responds to the perception of need. The shift in moral perspective is manifest by a change in the moral question from "What is just?" to "How to respond?" ([2], p. 23).

Whereas, the individual abstractly conceived is the moral starting-point for the justice perspective, in the care perspective, relationships are regarded as prior. Because the justice perspective, views the self as fundamentally unencumbered and autonomous, moral relationships are characterized by strict reciprocity and equality. Contract is thus regarded as the mechanism of moral association. In the care perspective, by contrast, the self and others are viewed as "interdependent" and action is characterized as "responsive" rather than "self-governing" or self-legislating ([2], p. 24). Since relationships are regarded in the care perspective as prior to individuals, unequal and unchosen (as well as equal and self-assumed) relationships can be accorded moral significance and responsiveness rather than contract becomes the basis for moral interaction.

Especially telling in the contrast between justice and care perspectives is the issue of moral failure. Because the autonomous individual is given priority in the justice perspective, respect for autonomy is regarded as the first principle of moral association. In other words, morality is seen as essentially a matter of "reciprocal non-interference" ([8], p. 47). Moral failure, therefore, is exemplified by those actions that involve unwelcome intervention into or interference with the life or choices of another. Such actions are variously identified as paternalistic, oppressive, tyrannical, etc. The paradigmatic example of such unwelcome interference is the encroachment by the state into the lives of individuals.

On the care perspective, humans are seen as interdependent rather than as isolated individuals. On this basis, morality is regarded as a matter of reciprocal attachment rather than reciprocal non-interference. Moral failure, therefore, is exemplified by "detachment, whether from self or others ... since it breeds moral blindness or indifference – a failure to discern or respond to need" ([2], p. 24). Moral failure, is a function of disengagement, whether it is manifested in our actions toward others or in our self-understanding (self-deception). Forms of moral failure include abandonment, neglect, indifference, evasion, deception, insensitivity, etc. Justice theory's commitment to impartiality as *the* moral point

of view and to a vision of ourselves as expert utility-calculators or rule followers encourages the kind of moral detachment that Gilligan condemns. For, by replacing the fragile notion of goodwill or benevolence with the supposedly sturdier notions of rights and contracts, the justice perspective may, in fact, contribute to a blunting of our moral sensitivities and to an impoverishment of our moral discourse. As Toulmin has argued, by insisting on impartiality and the mechanical application of principles, the justice perspective does much to ensure that our relationships with one another will be characterized by bureaucratic consistency rather than humane discretion ([42], p. 36). By contrast, emphasizing care as a legitimate moral motivation, ensures and gives moral credit to forms of relating that are ignored and even undermined by the justice perspective.

The moral saliencies highlighted by Gilligan's work can be summarized as follows. First, a central function of morality is the cultivation of traits of character and a sense of personal responsibility that will guide us in our relationships with particular others. As such, the quality of our responsiveness to others is of paramount importance. Second, the primary task of moral responsiveness is to see others as singular concrete individuals with unique histories and desires.[10] Responsiveness thus requires a moral point of view that is characterized by partiality. Third, moral response is called forth by the needs of others and our own ability to meet those needs through our acts or omissions. These needs may be explicitly articulated or they may be implied by the nature of an unequal or dependency relationship. Fourth, morally good caring requires the cultivation of desirable forms of emotion that will allow us to discern and to respond to the needs and concerns of others ([16], p. 11–15).

If the model of a deductive, principle-based system is definitive of moral theory, then we should not expect a theory so conceived to emerge from the insights of the care orientation [38, 41]. Rather, the vision of the care perspective would seem to be most akin to an Aristotelian virtue-based approach to moral deliberation and development. As Carse has pointed out, Aristotle's notion of phronesis or practical wisdom "outrun[s] any general rules or principles one might possibly devise" ([16], p. 18). In addition, and contrary to dispassionate justice theory, Aristotelian virtue consists in the dispositions to right emotion and right understanding as well as to right action ([16], p. 18).

5. JUSTICE AND CARE: THE IMPLICATIONS FOR MEDICAL ETHICAL THEORY

In my discussion of the implications of the justice and care perspectives for medical ethical theory, I will focus primarily on the theories of Engelhardt [33]

and Veatch [35], for their deontological liberal orientations make them most susceptible to the challenge of the care perspective.[11] Where appropriate, I will also point out features of utilitarian medical ethics that are called into question by an ethic of care.

In the medical and specifically clinical ethics literature, there are several authors who articulate views compatible with the emerging care ethic. These include Pellegrino and Thomasma [47–50], Cassell [51], Zaner [52] and Churchill [53, 54]. Others whose work either implicitly or explicitly echoes the care perspective are Levine [55], Povar [56], and Reich [57]. Cooper [58] and Fry [59] explicitly discuss the care perspective as it relates to nursing ethics. In what follows, I will emphasize features of Pellegrino and Thomasma's work that are congruent with an ethic of care.

In my discussion of the implications of the justice-care debate I will focus on three broad issues: (1) the locus of medical morality, (2) neutrality regarding goods vs. health as the end of medicine, and (3) contract vs. fiduciary beneficence as the basis of physician-patient trust.

5.1. The Locus of Medical Morality

5.1.1. Engelhardt: The Person as the Locus of Medical Morality

Justice-oriented medical ethics is constrained by the liberal demand that morally relevant individuals be regarded as fundamentally equal.[12] Thus, despite the fact that medical relationships are premised on the *in*equality of the patient and health care provider (viz., the physician has precisely those skills and resources that the patient lacks), justice-oriented medical ethical theories must depend on mechanisms that "promote" the patient to a position of virtual equality with the physician ([8], pp. 54–55). In Engelhardt's libertarian *The Foundations of Bioethics*, this mechanism takes the form of a Kantian construal of persons shorn of all but rational attributes. It is, Engelhardt says, "persons in this sense of [the noumenal ego] who exist as the constituting sources of the moral world" ([33], p. 150, note 18). For Engelhardt, the person is the locus of medical morality. Accordingly, the defining characteristics of personhood establish the moral boundaries of medicine.

In Engelhardt's scheme, these defining characteristics of personhood are (1) rationality, (2) self-consciousness, and (3) a moral sense ([33], p. 106). Like the Kantian noumenal ego, which is free from mechanistic causality, Engelhardt's Kantian person may not, by definition, be subject to force or interference. It is on this basis that Engelhardt establishes a libertarian medical ethics as rational conflict resolution without recourse to force ([33], p. 39).

There are a number of consequences for medical ethics that result from this

definition of persons. First, the principle of autonomy is given absolute priority over a principle of beneficence in Engelhardt's theory. Because persons are by definition inviolable, "authority for actions involving others in a secular pluralist society is derived from the free consent of those involved" ([33], p. 85). "Authority in health care is, therefore, contractual" ([33], p. 49). In other words, in Engelhardt's scheme, the doctor has no de facto duty of beneficence. Rather this duty arises out of the patient's explicit consent regarding the goods that she wants the doctor to achieve for her. "The content of a duty of beneficence", Engelhardt says, "is grounded in the principle of autonomy" ([33], p. 87). If, however, as Engelhardt argues, only consent can activate beneficent action, then his theory is not able to offer any explanation why a doctor should or would choose to benefit those who have not or cannot give consent.

Second, because they do not meet the criteria of personhood, (rationality, self-consciousness and a moral sense), and are thus not strictly speaking autonomous, infants and young children "fall outside the inner sanctum of morality" ([33], p. 108). In Engelhardt's theory, this means that there is no moral requirement on doctors or other health care workers to care for infants and children because, as "non-persons" these "entities" can make no moral claims. Engelhardt himself admits that his theory can offer no moral censure against infanticide ([33], p. 13, 116). It is thus that the defining characteristics of personhood establish the moral boundaries of medicine.

Although Engelhardt does allow that infants and children might be accorded protection on the basis of their "social personhood", the "social sense of persons", he says, "[is] justified in terms of various utilitarian and consequentialist considerations" ([33], p. 116). As such, the concerns of social persons will always be subordinate to the concerns of persons strictly defined. For, by definition, a libertarian theory gives priority to the principle of respect for autonomy (of strict persons) over consequentialist considerations (such as utility or beneficence) that might themselves jeopardize the freedom of strict persons.

Third, because the moral agent is strictly defined in terms of rational capacities, the fact of physical illness has virtually no moral significance in Engelhardt's theory. Illness matters not because it makes us anxious, vulnerable and dependent on someone else's help, but because the body is a substrate for rationality. The body's incapacity is significant only because it jeopardizes our status as persons ([33], p. 206). A view of personhood that excludes consideration of the body seems entirely inappropriate to a theory that articulates the ethics of medical encounters. A care ethic, by contrast, will acknowledge the emotional and physical significance of illness to the person whose embodiment and life choices are in jeopardy.

Fourth, because rationality, self-consciousness and a sense of praise and blame are the *only* features essential to moral agency, Engelhardt's theory has

made no provisions for the development, the encouragement or even the acknowledgment of care, concern, attentiveness or empathy as moral responses. If the physician fails to respond to the patient in these ways, he or she cannot, on Engelhardt's view, be morally blameworthy because these kinds of response are not regarded as morally salient. In other words, because the personhood status of individuals makes non-interference or respect for autonomy the preeminent moral requirement, then forms of neglect (which we ordinarily understand as *blameworthy* non-interference) will invite no moral censure.[13]

5.1.2. Veatch: Impartially Derived Principles as the Locus of Medical Morality

Recall that in justice theory, impartiality defines the moral point of view. Impartiality is prized because it guarantees that no one's interests will be specifically favored or disfavored in moral judgments. In this way maximal freedom is allowed to all. In Engelhardt's libertarian theory impartiality is a metaphysical characteristic of moral agents or persons, who are, literally, disinterested – shorn of all but rational attributes. For Veatch, by contrast, impartiality is a cognitive capacity that we realize through the mechanism of a Rawlsian veil of ignorance ([35], p. 121). Within the cognitive constraints of a veil of ignorance, rational contractors generate principles which Veatch says constitute "the moral order" ([35], p. 121) or "the moral structure" ([35], p. 123). For Veatch, therefore, medicine's moral significance is a function of these impartially derived principles of right. The principles (viz. contract-keeping, autonomy, honesty, avoiding killing, justice and beneficence) guarantee fairness in our moral relations because they have been generated from within an ahistorical, impartial framework where the interests of all are regarded equally.[14]

The generation of principles occurs at two levels in Veatch's theory; first, at the level of the prior or "basic social contract" and second, at the level of the contract between society and the medical profession. Whereas the social contract generates "the most basic social principles for human interaction" ([35], p. 110), the second contract generates the role-specific duties unique to health care practitioners.[15] A third contract, this one between individual providers and patients does not operate under the constraints of impartiality (viz., it is not hypothetical and does not generate principles) but is instead intended to capture any "residuum" ([35], p. 135) that may be relevant to the balancing of principles generated by the two prior contracts. Because, for Veatch, "the moral community is one of impartiality" ([35], p. 119), his theory strongly suggests that what goes on at the level of the third contract – the moment of real non-hypothetical interaction between individual doctors and patients – is not really *moral* at all. This contract theory is based on the presumption that the domain of morality and thus medical morality lies entirely within the bounds of impartially

generated principles. There are at least two related consequences for medical ethics that result from this presumption.

First, like Engelhardt's project, Veatch's theory of medical ethics can give no moral recognition to the skills of sensitivity, care, empathy and attentiveness that guide us in our relationships with particular others. As a result, this theory can give no concrete moral guidance to health care providers and patients who must communicate with one another to negotiate the full interpersonal scope of the patient's care.

This points to second and related deficiency in principle-driven moral theories such as Veatch's. Although doctors and patients are constrained in Veatch's theory by abstract principles, there is no recognition given to those capacities that, in fact, enable us to discern when and how such principles might be translated to a particular case. As Carse notes, however, the application or balancing of principles itself *depends upon* this unacknowledged capacity for emotional sensitivity: "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" ([16], p. 11). In short, the principled resolution of particular moral dilemmas is not itself possible from a vantage point of utter impartiality. And yet, the capacities of emotional attunement and contextual sensitivity that discern when, where and how principles may be used, are accorded no moral authority in an impartialist scheme. In Veatch's theory, the context for the third contract between individual patients and providers is not considered a genuinely 'moral' (viz., impartial) context. As a result, this theory offers no assistance on the skills required for the decent and caring conversation that must certainly precede and be the basis for such a thing as a 'contract'.

5.1.3. Pellegrino and Thomasma: The Healing Relationship as the Locus of Medical Morality

Because justice theory interprets medicine, and all other human activities, on the model of free exchange between equals, the distinctive features of the medical relationship are all but ignored in deontological liberal medical ethics. To wit, in the justice-oriented theories of Engelhardt and Veatch, it is either abstract personhood or impartially derived principles of right that constitute the locus of medicine's moral significance.

What would medical ethics look like if it honored the vision of the care perspective? First and foremost, it would be attentive to the uniqueness of the clinical relationship – the encounter between the physician and someone who is ill. A care-oriented theory will, thus, anchor medical morality to a phenomenology of the healing relationship (47–49, 52]. In this section I will outline and

comment on Pellegrino and Thomasma's notion of the healing relationship as a unique human activity. I will show how this approach to medical ethics is compatible with a care orientation's emphasis on human need and responsiveness to particular others.

The medical relationship is distinguished first by the vulnerability of the ill patient ([48], p. 44). Illness disrupts our self-perception and, thus, our relationship to the world and to our future in it. Whereas we ordinarily take for granted the consonance between our bodies and our selves, in illness, our body ceases to be a transparent mode of our self expression. Instead my body (or mind) becomes an obstacle to my self expression. It is this experience of illness that Pellegrino so aptly describes as "an ontological assault" ([48], p. 44). It is characterized by a sense of disruption, by anxiety, uncertainty and often fear and pain, which together force us to place ourselves under the power of another person – the health professional. The vulnerability that we experience as a result of illness is augmented by the fact that in order to allow the possibility of benefit, we must reveal our bodies, our personal lives and personal histories to another. We must entrust to the health professional those things about which we care most deeply.

The vulnerability of the ill person itself calls medicine and physicians into existence and gives rise to what Pellegrino calls "the act of profession" ([48], p. 46). This act is literally the "declaration" that the physician or other health care provider makes when he or she offers services to the patient. By offering oneself as a physician, an individual "'declares aloud' that he or she has special knowledge or skills, that he can heal, or help and that he will do so in the patient's interest" ([48], p. 46). This promise imposes a fiduciary burden on the physician because it fosters a dependency relation.

The relationship formed by the one in need and the one who promises to heal or help is thus characterized by a fundamental *inequality*. The physician has precisely the knowledge, skill and resources that the patient lacks. For this reason, the model of contract, which is premised on the *equality* of the participants, does not adequately represent the relationship [61].

Given the inequality between them, the physician's pledge to act in the patient's interest is necessarily a pledge that he or she will *not* exploit the patient's vulnerability, and will also help in positive ways to *diminish* that vulnerability as much as possible. In this way, the structure of the relationship allows us to reinterpret the notion of respect for patient autonomy. Our willingness to become patients and to depend on the physician's resources is an acknowledgment that our valued autonomy is limited by the circumstances of illness. Thus, it is only by *enhancing* the patient's diminished autonomy that the physician can genuinely serve the patient's interests. Autonomy is not respected as a matter of principle, as we find in justice theory, but rather, because it is one

essential aspect of doing the patient's good.

The perspective of care emphasizes our moral responsibilities to particular others. A care-oriented medical ethics will, likewise, highlight those features of the physician-patient interaction where treatment options and explanations are particularized into a recommendation for the individual patient. The moral and technical particularization of medical care is captured in Pellegrino's notion of *the act of medicine*. This act, he says, is "the vehicle of authenticity and the bridge which joins the need of the one seeking help with the promise of the one professing to help" ([48], p. 47). It is the therapeutic act, the ultimate end toward which the physician-patient relationship aims, the telos of the clinical encounter.

The act of medicine is built upon the diagnostic and prognostic questions "What is wrong?" and "What can be done?". The information gleaned in addressing these questions must then be oriented to the needs and desires of the particular patient. The act of medicine is thus the response to the subsequent therapeutic question: "What should be done?". As Pellegrino describes it, the act of medicine is "*a right and good healing action taken in the interests of a particular patient*" ([48], p. 47; emphasis added). The healing action is *right* in the sense that it is technically, scientifically and logically sound and in conformity with the patient's medical needs. The healing action is *good* in the sense that it accords with the goals and values of the patient in the achievement of healing or wholeness. A morally sound response will necessarily be attentive to the patient as a particular, concrete individual.

Understanding the unique structure of the healing relationship as the locus of medical morality has at least two consequences for medical ethical theory. First, such a theory will acknowledge that moral responsiveness on the part of the physician (and patient) will require genuine and open dialogue. Bioethical education and medical ethical theory can foster this kind of dialogue by accentuating the development of communication skills and empathic dispositions that will enable healthcare providers and patients to listen and speak to one another more effectively ([16], p. 21; [51]). To this end, a care oriented medical ethic will make demands on the character of the physician to develop not only self understanding but to cultivate emotional and interpersonal skills that go beyond 'patient management' to genuine 'patient care'. In the language of moral theory, a care oriented medical ethics will be virtue-theoretic.[16]

Attention to the structure of the healing relationship has a second consequence for medical ethics. In Engelhardt's libertarian theory the physician's duty of beneficence is secondary and derivative; it is a function of patient consent. For Veatch, "beneficence is a lower order principle lexically ranked after the non-consequentialist principles [of contract-keeping, autonomy, truthtelling, etc.]" ([35], p. 303). By contrast, a medical ethic oriented to care will regard the physician's duty to benefit the patient as a *primary* responsibility

arising from the inherent asymmetry of the relationship. It is because the physician *as* a physician is in a position of greater power that he or she bears a moral burden of care relative to the patient. This obligation to act for the patient's good takes its cue from the commitment to health upon which the relationship is predicated. In a care theory, the demand for beneficent action on the part of the physician is never a license for strongly paternalistic action.

5.2. Neutrality Regarding Goods vs. Health as the End of Medicine

It is a fundamental tenet of liberalism that if individual freedom is to flourish, it cannot be constrained by the imposition of one person's conception of the good on another. Deontological liberal moral theory thus guarantees equal maximal liberty to individuals by avoiding any systematic commitment to particular goods. In other words, deontological theory gives priority to the right (universal procedural principles) over the good however it may be conceived.

In order to be consistent with these deontological constraints, justice-oriented medical ethical theories must either deny or diminish the importance of health as a good that conditions the medical relationship. For Engelhardt, it is the free choices of individual men and women that fashion both the substance and the limits of medicine ([33], p. 250). The doctor and patient, as autonomous persons, have no de facto common interest in healing, rather, their interests are discovered through contractual negotiation. For this reason, Engelhardt says, that medicine is not the agent of the ill and injured, "it is the agent of persons" ([33], p. 241). Thus, doctors have no obligations to the sick per se, but rather, only to persons.

A care perspective, on the other hand, because it is oriented to human needs rather than to the rights of citizens per se, will readily acknowledge the human commitment to health or healing as the motivating force behind medical activity. As such, a care-oriented medical ethics will be teleological rather than deontological in character.[17] It will give priority to the good viz., the good healing action for the *particular* patient ([48], p. 44) over the right. Further, on this scheme, patient autonomy is respected not as a matter of principle (as it is in justice theory) but because autonomy itself is a value or good that cannot be undermined if the patient's good is to be served.

5.3. Contract vs. Fiduciary Beneficence as the Basis of Physician-Patient Trust

As I have said, the paradigm of liberal citizenship is premised on the conviction that individuals are fundamentally equal. It is a tenet of deontological liberal theories that this equality is best served by an arrangement where parties can together reach mutually advantageous agreements. On this basis, contract

emerges as the fundamental mechanism of moral association and the basis of trust. Contract is thought to provide the best guarantee that the freedoms of one individual will not be usurped by another. In justice-oriented medical ethics, therefore, the limits of the contract define the limits of the trust between physician and patient.

There are several problems with this model of physician-patient trust. First, it fails to recognize that the circumstances of illness – anxiety, pain, dependence, and, at times, emergency needs – often undermine the patient's ability to negotiate the conditions of her treatment. The patient is not, in fact, in a position of equal bargaining power. Despite a laudable effort to acknowledge the patient as a person, deontological liberal medical ethics loses sight of the fact that the patient who is a person is *also* a patient.

Second, this model unrealistically assumes that our expectations of physician responsibility can be satisfied by the limited specificity of a contract. Ignored here is the fact that medical care inevitably consists of a continuous series of judgments and competent acts that cannot be anticipated by a contract ([47], p. 110). If, on the other hand, the contract model attempts to allow for the unexpected by permitting the use of phrases such as 'as needed' or 'as indicated', it ultimately defeats itself by widening the context of trust *beyond* the specificity of the contract ([50], p. 103). But, this is exactly what the contract model must deny. Insofar as this model limits the region of physician-patient trust to the provisions of the contract, it cannot give any moral credit or authority to the discretionary judgment of the physician to perform a task 'as needed'.

From the point of view of a care-oriented medical ethics, the physician-patient relationship is, in fact, initiated out of a recognition of fundamental *inequality*. My trust is invited by the physician's public declaration *as* a physician that she has the skill and resources to meet my needs and to care for the things that I care enough about to entrust them to her [60]. Thus, in a care-oriented medical ethics such as Pellegrino's and Thomasma's, the contract model of the physician-patient relationship is rejected in favor of a model of "fiduciary beneficence" ([47], ch. 2–4).

This model, unlike the contractual model, conveys the fact that the physician *as* a physician holds the patient's good in trust. The physician has a *de facto* duty of beneficence, therefore, that preexists and underscores the articulation of specific goods by the patient. It is on this basis that we have moral expectations of physicians that go beyond the limited specificity achievable by contract. In addition, the physician's de facto duty to act in the patient's best interests explains why we have legitimate moral expectations that our *un*chosen relationships with physicians (for example, in an emergency) will serve our health interests.

On the care model, moral requirements are not conditioned by impartiality

and universality, nor are they generated exclusively by agreement between individuals who can fully articulate their needs. In fact, the care perspective insists that moral requirements frequently emerge within a relationship precisely *because* a vulnerable member of that relationship is *not* in a position to spell out his or her needs. For this reason, a morality of care, unlike a justice-oriented morality, does not depend on the pretense of contractual equilibrium as the basis for moral action.

6. CONCLUSION

From the point of view of theory, a justice and a care-oriented medical ethics are structured in opposite directions. The former takes as its starting point the paradigm of liberal citizenship. The autonomous individual is regarded as prior to the state and this relationship is made paradigmatic of all moral association both public and private. Deontological liberal theories of medical ethics, therefore, are 'top-down' theories that begin with broad public policy concerns, move to social and health policy and then go on to apply relevant principles to the physician-patient relationship. As Engelhardt asserts, "secular ethics, and therefore secular bioethics, is an enterprise in public policy making" ([33], p. 48). Similarly, for Veatch, the actual contract negotiated between individual physicians and patients is constrained by the demands of two prior contracts: the basic social contract and the contract between society and the health profession ([35], ch. 5).[18]

It is exactly this sort of theoretical orientation that is denoted by the expression 'applied ethics'. Ethical principles initially derived from a deontological liberal framework are then 'applied' to the context of medicine. In other words, for Engelhardt and Veatch, the physician-patient relationship is not *in itself* morally distinctive. Rather, it *becomes* morally significant only to the extent that it provides an opportunity for the application of impartially derived principles of right. For this reason, neither Engelhardt's libertarian nor Veatch's contractarian theory requires or offers any description of clinical medicine as a unique human activity.

Such an orientation to medical ethics is, however, in the end, self-defeating. For if, as Veatch and Engelhardt maintain, there is nothing morally distinctive about medical relationships, then neither theorist has given any plausible reason why such relationships would require the *specific* theoretical attention given to them in deontological liberal theories of medical ethics. In other words, if we believe that the moral demands on medicine are no different than those that constrain moral association generally speaking, then why would we require a distinct discipline (medical ethics) to discuss medical moral problems?

The care perspective, by contrast, is oriented to the individual needs that arise within particular relationships. From the care perspective, therefore, Gilligan says, the autonomous agent recedes and "the *relationship* becomes the figure, defining the self and others. Within the context of relationship, the self as a moral agent perceives and responds to the perception of need. The shift in moral perspective is manifest by a change in the moral question from 'What is just?' to 'How to respond?'" ([2], p. 23). Of the utmost importance, therefore, in the care perspective is a thorough understanding of the nature of the relationship in which the parties are involved: (1) the expectations, desires, and/or fears that caused the parties to come together in the first place, (2) the goods that the parties regard as attainable only through the cooperation afforded by the relationship, and (3) the relative power of the parties in the relationship. It is only on the basis of our understanding of the *particular* relationship in which we are engaged with *particular* individuals that we can have an appropriate moral response. It is precisely this emphasis on relationship that is honored in Pellegrino's and Thomasma's medical ethic. And in this way, their project turns deontological liberalism on its head.

Instead of beginning with the public and institutional norms of liberal theory and then applying them to the medical context, Pellegrino and Thomasma argue that the moral norms that govern clinical activity are grounded in an ontology of the healing relationship. Taking actual patient-physician relationships as its starting point, a care-oriented medical ethic has a broader compass that necessarily includes those forms of human attachment and responsiveness, such as care, concern and sensitivity that are lost to impartialist theories.

Because an impartialist framework offers us no guidance in our relationships with particular concrete others, reliance on such a framework in medical ethics has the effect of distancing the physician and the patient from one another by the interposition of principles and rules. Ironically, a principle-driven medical ethics merely reenforces and encourages the attitude of physician detachment that medical ethics is ostensibly intended to heal.

Acknowledgements – I would like to thank Susan Stocker for her helpful comments on an earlier draft of this paper.

NOTES

[1] The terms of the debate are also echoed in Tannen's socio-linguistic analysis of the conversation styles of women and men [14], and Rosener's work on male and female management styles [15].

[2] Readers are also referred to an excellent article by Alisa Carse that outlines the significance of the care perspective for bioethical education. See [16].

[3] Kohlberg's work derives explicitly from the tradition of *deontological* liberalism. For this reason, it is the deontological, rather than the utilitarian or consequentialist strain of

liberalism that is the direct target of Gilligan's work. However, despite the differences between deontology and utilitarianism, there are certain assumptions that are common to both. Such assumptions include (1) a theoretical commitment to impartiality as the defining feature of the moral point of view, (2) a theoretical indifference to the specific aims and identities of persons ([19], p. 5; [20]; [21], pp. 108–109), and (3) a presumption that abstract principles or rules are exhaustive of ethics. To the extent that utilitarian theories rely on these assumptions, they are equally vulnerable to the challenge of the care perspective.

[4] However, as Annette Baier points out, despite the fact that they give no theoretical acknowledgment to such skills, justice-oriented moral theory must nevertheless depend upon all of the nurturing and benevolent impulses that, among other things, guarantee the survival of the young ([8], p. 53). Without theoretical provisions for the conditions of nurture and care, these views cannot account for the continued existence of the societies they assume. Thus, although justice theory fails to give these dispositions moral standing, it simultaneously relies upon them to ground its claims. Baier offers a succinct appraisal of this double standard: "a decent morality will *not* depend for its stability on forces to which it gives no moral recognition" (Baier quoted in [22], p. 630).

[5] It would be anachronistic to use the feminine as well as the masculine pronoun here because, despite the fact that Kant's theory of moral agency has a presumably universal human application he, in fact, expressed grave doubts about women's ability to act according to principle: "Women will avoid the wicked not because it is unright, but because it is ugly ... Nothing of duty, nothing of compulsion, nothing of obligation! ... I hardly believe that the fair sex is capable of principles" [30]. If she is not able to act according to principle or in accordance with duty, then she is not, by Kantian criteria, autonomous. For a general discussion of the status accorded to women by classical liberal theorists, see Brennan and Pateman [31].

[6] In deontological liberal medical ethical theories, such as that offered by Engelhardt [32], this Kantian influence shows up as the primacy of the principle of autonomy in medical moral deliberation.

[7] It is this Kantian construal of the self that grounds Engelhardt's libertarian conception of morality and medical morality as "a means for resolving controversies ... on bases other than direct or indirect appeals to force" ([33], p. 39).

In Rawls's *A Theory of Justice* the impartiality of the moral subject (and thus of the conditions surrounding the formulation of the principles of justice) is guaranteed by the mechanism of the veil of ignorance – "the point of view from which [Kantian] noumenal selves see the world" ([34], p. 255). By rendering contractors ignorant of their place in society, class, position, status, etc., the veil of ignorance "nullif[ies] the effects of specific contingencies which put men at odds and tempt them to exploit social and natural circumstances to their own advantage" ([34], p. 136). In *A Theory of Medical Ethics*, Veatch's notion of the moral point of view – the point of view from which we regard the welfare of all equally – is an explicit rendering of the Rawlsian veil of ignorance ([35], p. 183).

[8] It should be pointed out that the liberal or modern notion of justice: the government of social relationships by means of impartial principles or laws, is itself a narrow construal of justice. Notably absent from this conception is the notion of *equity* that we find at the center of classical conceptions of justice. It is precisely this omission that constitutes one of the main weaknesses of the 'justice perspective'; it adheres to uniform principles at the expense of responsiveness and discretion. See Toulmin [42].

[9] The phrase "deontological liberalism" is Michael Sandel's ([44], p. 1). This expression is a more descriptive label for the major tradition indicated by Gilligan's phrase "justice perspective".

[10] For justice theorists, by contrast, "the ultimate moral concern is with morality itself – with morally right action and principle; moral responsiveness is mediated by adherence to principle" ([45], p. 476–477).

[11] My discussion is drawn from the extensive critique of deontological liberal medical ethics that I offer elsewhere. See [46].

[12] In deontological theories, individuals are regarded as equally important. Utilitarian theories, however, cast individuals as equally *un*important. As Sen and Williams point out, "Essentially, utilitarianism sees persons as locations of their respective utilities – as the sites at which such activities as desiring and having pain and pleasure take place ... Persons do not count as individuals in this any more than individual petrol tanks do in the analysis of national consumption of petroleum" ([19], p. 4). In either type of theory, it is only the sameness of individuals that is worthy of moral attention.

[13] Engelhardt does argue that the principle of beneficence constitutes one "dimension of the moral world" alongside the "morality of mutual respect" ([33], pp. 78–84), however his use of the word "moral" in reference to beneficence belies the fact that throughout his argument, the criteria for *moral* justification are tied exclusively to the morality of mutual respect. As Engelhardt himself says, the moral beliefs and choices that ground the principle of beneficence "cannot be decisively demonstrated to be morally authoritative..." ([33], p. 51). For more on this see ([46], ch. 4).

[14] The idea of an ahistorical hypothetical contract situation such as Veatch's – where the contractors are positioned behind a "veil of ignorance" – is unacceptable on the libertarian view because it risks undermining the freedoms of *real* individuals by constraining their choices within a preordained framework. For the libertarian, legitimate moral resolutions are *unanimous* – they are resolutions that have been endorsed by *every* individual ([33], p. 43). For the contractarian, however, an impartial original position will generate principles that are "*in principle accessible to all*" ([35], p. 88; emphasis added). Thus, for the contractarian, *virtual* rather than *actual* unanimity is morally sufficient.

[15] Veatch defines role-specific duties as the moral duties that one acquires when "one moves into special roles" ([60], p. 4). Given this definition, one must ask why Veatch's rational contractors who themselves generate "the moral order" would in fact regard the physician's role as "special" enough to require the imposition of role-specific duties in the first place. And if there is, in fact, something *so* distinctive about what goes on between physicians and patients that we are compelled to hold physicians to higher standards, are we not simply affirming that we already – *before* the generation of any principles – regard the relationship as morally distinctive? But, this is exactly what Veatch denies when he asserts that medicine's moral significance is *a function of* impartially generated principles. In the end, and on the basis of Veatch's definition of the physician's role as "special," we must conclude that his principles of medical ethics are merely an ex post facto construction onto a situation that we *already* regard as morally significant.

[16] For Veatch, by contrast, good character and virtuous dispositions are theoretically dispensable because they are superceded by generally acknowledged principles of right. As he puts it, "If we could be assured that the physician would do the right thing we would not really be concerned about motivation ... Virtuous character in a world of stranger medicine is at best a luxury and at worst a deterrent to right action" ([62], p. 399). Veatch's argument is faulty, however, on at least two counts. First, as we have already seen, the application of principles itself presupposes traits of character such as sensitivity and discretion that are not themselves principle-governed. Second, because the requirements of medical care can never be precisely anticipated in a physician-patient contract, medical ethical theory must give moral recognition to the capacity for discretionary judgment that is a necessary part of the treatment process. A care oriented theory will place moral limits on discretionary judgment, not by replacing it with rules, but by distinguishing between virtuous and vicious or caring and uncaring responses. See ([47], ch. 9).

[17] When I say teleological here, I am referring to something akin to Aristotle's virtue ethics rather than to any utilitarian scheme. Some pluralist utilitarian theories have included the notion of health within the calculation of the greatest good ([63], p. 28).

However, it remains to be seen whether consequentialist theories can overcome their theoretical biases toward abstract principles and a minimal self in order to be more inclusive of a care perspective.

[18] Insofar as a utilitarian approach is ultimately concerned with the general welfare, utilitarian medical ethics also tends to emphasize questions of social and health policy. Because utility maximization schemes are unconcerned about just who may or may not be touched by our actions, utilitarian medical ethics is largely unconcerned to explore the healing relationship as a unique human activity.

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