THEORY IN BIOMEDICAL ETHICS:
THE COMPATIBILITY of PRINCIPLISM and CARE ETHICS

by

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ABSTRACT

The subject of this thesis is the relationship between "principlism," a dominant trend in the theory of biomedical ethics, and a recently articulated alternative account of ethics known as "care ethics." I will argue that, rather than being competing or mutually exclusive approaches to moral theory, these two perspectives are compatible and that their partnership is mutually beneficial.

I will situate my arguments within the larger philosophical debate between theorists and anti-theorists. I will contend that principlism has evolved to a position more closely allied with anti-theory than with theory. Due to the fact that care ethics has been nurtured by anti-theoretical roots, principlism's current philosophical orientation predicts the compatibility of the two perspectives in biomedical ethics.

By clarifying terminology and providing reasons for promoting care ethics, I will elucidate some of the causes for the assumption that care ethics and principlism are unsuited to each other. By demonstrating how care ethics can inform the principles of principlism without offending their structure, I will indicate how the two approaches to biomedical ethics are actually well matched.

To further dispel scepticism, I will address the criticism that care ethics does not display the necessary methodological requirements for moral theory. I will contend not only that care ethics can meet the standards for a legitimate philosophical school of thought and that it does not fall into the disarray of situationalism, but also that the methodological characteristics it possesses should be adopted by conventional moral theory.

Using these strategies, I intend to argue that the contributions from care ethics to biomedical ethics are abundant, and that the partnership between principlism and care ethics is not only possible but that it should be encouraged and promoted.
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INTRODUCTION

In the past two decades, the subject of biomedical ethics has enjoyed considerable attention from academics, professionals and lay people. Initially, the emergence of this field was accompanied by innovative theorizing; however, more recently, conventional methods of analyzing and discussing the ethical issues which arise in the arena of health care have become accepted as the status quo. Almost invariably, these methods employ four common reference points, composed of the principles of 1) autonomy, 2) beneficence, 3) non-maleficence and 4) justice. As K. Danner Clouser and Bernard Gert explain, these principles have become the "mantra of biomedical ethics" (Clouser & Gert, 1990:219).

Many of the general textbooks, as well as the academic work (Gillon, 1994; Baylis, Downie, Freedman, Hoffmaster & Sherwin, 1995) which is currently being done in this area, tend to take these principles for granted (Hoffmaster, 1992). Books on biomedical ethics are often issue-oriented (Mappes & Zembaty, 1991; Pence, 1995), as opposed to being focused on the fundamental tenets which underlie the ethical perspectives which they adopt. The editors of such texts usually identify a number of crisis topics such as abortion, euthanasia, the distribution of health care dollars in times of scarcity, etc. These areas are then dealt with using the familiar principles enumerated above. For instance, abortion is repeatedly addressed, either defended by the principle of a pregnant woman's autonomy (Warren, 1984), or refuted by the principle of beneficence - or at least non-maleficence - towards the fetus (Noonan, 1970).

In recent years, there has been a resurgence of interest in the fundamental characteristics of the generic optic which is employed to find solutions to ethical dilemmas. Some authors suggest that this perspective is myopic, or astigmatic. What is needed is a corrective lens which can help us more clearly address the issues which arise in biomedical ethics. New optics in the literature of ethics in general, and of health care ethics in particular, attempt to both diagnose and find the right prescription for the current state of biomedical ethics. Among these new approaches is a perspective known as "care ethics."  

1 In order to contrast the tenets of care ethics with those of conventional philosophies, I will refer to the latter as "justice ethics," using the terminology which Carol Gilligan coined when she originally observed the distinctive characteristics of care ethics (Gilligan, 1982).
Laura Purdy corroborates this account in her explanation that

[i]n the last few years, we have been venturing into more theoretical territory, and there has been an extraordinary explosion of imaginative new ideas. Among them are persuasive criticisms of widely accepted assumptions and new models of human interaction (Purdy, 1994:9).

One of the "widely accepted assumptions" to which Purdy refers, and which I assess in light of the premises of care ethics, is the belief that ethical discussion in the field of medicine can be adequately encompassed by the quartet of principles which constitute the "mantra" of biomedical ethics. According to my analysis of the care ethics literature, proponents of care ethics also challenge assumptions in the following areas: 1) epistemological claims about legitimate sources of knowledge; 2) methods of adjudication among the claims different principles make with regard to a given dilemma; 3) the values which are promoted by principles; 4) and the techniques used to respect and uphold the values which are identified.

With regard to the first of these issues, the epistemology of conventional moral theories, and (allegedly) biomedical ethics, puts too much emphasis on rational, abstract, radically autonomous reasoning. The results of such reasoning are supposedly recognizable and generalizable, at least within a given population. Care ethics, on the other hand, contends that legitimate sources of knowledge can derive from emotions, interdependency and connectedness.

Care ethics differs from traditional moral theories and (I will suggest only partly, from) biomedical ethics on methods of adjudication among prescriptions derived from different principles or approaches insofar as it does not encourage hierarchical, absolute, categorical structures among diverging claims or interests, such as those evident in theories such as Kantianism (perfect and imperfect duties), and utilitarianism (categorical consequentialism, be it rule or act utilitarianism).

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2 The qualification "radically autonomous" of the term "reasoning" differs from the results of reasoning, which could lead to radical autonomy. Radically autonomous reasoning supposedly occurs in the absence of any internalized influences, such as emotional connections to others, intuitions, feelings, socialization, etc. Consequently, some conventional moral theories require radically autonomous reasoning in order to effect radical autonomy. Other approaches to autonomy do not view radically autonomous reasoning as necessary to autonomy, and in some cases, see it as an impediment to autonomy.
With regard to the third item on which care ethics and traditional philosophy and biomedical ethics differ, proponents of care ethics maintain that there are several criteria for which traditional philosophical values, such as autonomy, consistency, universalism, fail to account. In conjunction with the epistemological claim, care ethics gives value to emotional states. It does not, for instance, associate mild depression with incompetence (Ackerman, 1982; Mappes & Zembaty, 1991:631). Care ethics valorizes relationships and interconnectedness, thereby allowing more states of being to count ethically than simply those states which are associated with narrow conceptions of autonomy. What care ethics is able to see as valuable is also dependent on its attention to contextual detail. This does not reduce to situation ethics, but rather, posits that the level at which conventional philosophy usually stops its search for morally significant similarities and differences is too general. The current delineation between legitimate and illegitimate evidence for moral judgment encourages moral considerations which are very general in nature. Conventional philosophy ignores admissible evidence for moral adjudication which is more sensitive to particularity.

Finally, regarding the fourth issue on which care ethics challenges its predecessors, care ethics claims that the recognition of different values requires different kinds of treatment. The acknowledgement, for instance, that emotional vulnerability is a legitimate and important state to recognize and address means that techniques such as comfort, perhaps touch, sympathetic listening, etc., are valued as much as are scientific techniques of cure, derived from the protocol of a purely medical model of patient treatment.

The philosophical parent of care ethics, (although its genesis and history can be traced to writers including David Hume, Annette Baier, and, in the eyes of some, to various existentialists (Sartre and Habermas) and anti-theorists (MacIntyre, Jonsen & Toulmin) (Tong, 1995)), is, generically speaking, feminism. Conversely, as might be suspected, conventional philosophy and current biomedical ethics are perceived by advocates of care ethics as the progeny of patriarchal thought. In line with this association, Marsha Hanen and Kai Neilson refer to Annette Baier's romantic vision for the future of these two different types of philosophy:

In her provocative discussion of the challenge posed to the traditional impartialist, justice-focused conception of morality by the new-wave care perspective in ethics, Annette Baier calls for "a 'marriage of the old male and the newly articulated
female...moral wisdom', to produce a new 'cooperative' moral theory that 'harmonize[s] justice and care'" (Hanen & Neilson, 1987).

Others might claim that the nursing profession is a progenitor of care ethics. I will argue in this thesis that it is in the practices of nursing that care ethics may have the best chance for growth to maturity. It is not nursing itself, however, despite its identification as a "caring" profession, that generates, and justifies "care ethics."

In support of Baier’s vision, I agree with the possibility of a synthesis between care ethics and more conventional forms of moral philosophy. In this thesis, however, I will only address the possibility of a harmonious union between care ethics and biomedical ethics. Rather than speaking of biomedical ethics in general, I will isolate a particular, although very common version often referred to as "principlism." This conception of biomedical ethics, championed by Tom Beauchamp and James F. Childress in their editions of Principles of Biomedical Ethics, employs the four principles of autonomy, beneficence, non-maleficence and justice, as do most other prominent (North American) theories of biomedical ethics. What is unique about Beauchamp and Childress’ version of biomedical ethics is that it stipulates abstract equality, which translates into contextual flexibility, among the principles it endorses. In this sense, it is allied with the tenet of care ethics which rejects rigid hierarchical structures and priorities.

Furthermore, Beauchamp and Childress explain that the content, in addition to the form, of the principles they endorse is subject to re-definition. This flexibility invites care ethics to imbue principlism with the kind of epistemological data which it identifies as valuable. In turn, the insertion of new epistemological information will influence the kinds of values which the principles can promote. The acknowledgment of new values, which the unedited version of principlism is blind to, will affect the kinds of techniques which will be employed in the attempt to respect them. Through this kind of partnership between them, biomedical ethics and care ethics can both be more fully actualized than if they stand alone.

This introduction outlines the general intent of this thesis: to show that the version of biomedical ethics known as principlism can indeed be conjoined with care ethics in order to accommodate claims such as Jean Watson’s that "the field of traditional biomedical ethics is incomplete and inadequate when it comes to issues of care and caring" (Watson, 1988:1).

To support this thesis, I will address the following issues in the subsequent seven
In Chapter I, I will review the history, and give an explanation for, the popularity of the four principles of biomedical ethics: autonomy, beneficence, non-maleficence and justice. I will look at this history primarily from an interest in these four principles, rather than from some other framework, such as political climate, or liberal democratic doctrine. Consequently, I will explain from the perspective of biomedical ethics why and how the four principles, now so widely endorsed, came to have their respective places in the dominant ethical framework. The tone of this explanation, however, will be underscored by the liberal ideology manifested in the twentieth century’s ever increasing concern for individual rights. I will also give an alternative account for the adoption of these principles which explains their appeal not from the perspective of rights and justice, but rather, from a more sociological conception of the developments in health care in the past one hundred years. The version of the history of biomedical ethics I will present claims that factors such as the replacement of small communities by mega cities, the invention of complex technology, the development of large institutions such as hospitals and the interest of scientific research qua research led to the phenomenon that David J. Rothman characterizes as, "strangers at the bedside" (Rothman, 1991). Rothman postulates that the close relationships of trust established due to the intimacy provided by small communities were lost, and the resulting mistrust necessitated the artificial regulation of interpersonal interaction by means of principles and rules.

In Chapter II, I will engage in a philosophical examination of one version of principlism, namely that of Beauchamp and Childress. After explaining its particularities, I will focus on the criticisms it receives from another philosophical perspective, namely what I will refer to as the "grand-theoretical" perspective. Grand-theory reflects what is sometimes known as the theoretical, rational or foundational position. Although this philosophical camp is often associated with foundationalist doctrines of truth, in the context of this thesis, the grand-theorists I document are important because of their endorsement of rigid, hierarchical relations among principles. These theorists contend that abstract equality among principles is insufficient in an ethical system. Rather, they require strict rules of superiority, subordination and derivation for the construction of an ethic. According to these criteria, K. Danner Clouser, Bernard Gert and Ronald Green, who lead the grand-theorist debate in the context of biomedical ethics, argue that the principlism of
Beauchamp and Childress cannot qualify as a legitimate ethical theory.

In Chapter III, I will look at authors who adopt an "anti-theoretical" philosophical position. The general tenets of anti-theorists include the rejection of static, absolute, hierarchical relations among principles; denial of the claim that principles are derived solely from rationalist abstractions; and negation of the premise that all ethical decisions are universalizable without a sufficient degree of sensitivity to context and particularity. Interestingly, these stipulations are very similar to those stated earlier as examples of the philosophical underpinnings of care ethics. The arguments I will present from the anti-theoretical perspective are Henk ten Have's comparison between North American and European deontology, Pinit Ratanakul's exposition on Buddhism and compassion, Richard M. Zaner's discussion of phenomenology, and James F. Drane's treatise on virtues. These arguments all focus their criticisms against what they term "principlism," although it is unclear if they consistently refer to Beauchamp and Childress' version of it, and if so, to what edition of Beauchamp and Childress' Principles of Biomedical Ethics. In any case, whether these are pseudo or real debates, they demonstrate that there are many other philosophical trends in addition to care ethics, which focus their attention on restructuring the fundamental premises of biomedical ethics. What will be determined in the course of the subsequent chapters is whether care ethics' criticisms of principlism differ from those of the anti-theorists, and if so, in which ways.

In Chapter IV, I will introduce the ideas behind the term "care ethics." In addition to a discussion of the themes listed above, many clarifications will be made. Firstly, despite its birth in feminist ethics, I will disassociate my treatise on care ethics from the objectives of feminism. It is not the intent of this thesis to promote a perspective on the basis of feminism's ideology concerning the oppression of women. Rather, my goal is to examine the philosophical basis of care ethics in an attempt to assess its viability as a moral theory, and its compatibility and possible union with principlism. Furthermore, as I have already mentioned, I will attempt to clarify, and to distance myself from, the abundant claims of nursing theorists some of whom promote care ethics for reasons of professional identification. Finally, I will distinguish the "concept" of care from an "ethics" of care. This argument has two components. The first of these draws a distinction between techniques of caring behaviour and care ethics. Care ethics is not synonymous with caring strategies, although such strategies could indeed result from the
recognition of the values promoted by care ethics. The second component of this argument is that care ethics is not synonymous with an ethics of feelings or emotions. The argument of some nursing theorists is that if caring feelings and attitudes are embraced, correct ethical decisions will necessarily result. This is not only an unfortunate co-option of the term "care ethics," deriving from a mistaken conflation of a perspective with a state of being, but it is also a dangerous line of thought that proponents of care ethics must scrupulously avoid.

In Chapter V, I will look in detail at how the criteria of care ethics, described earlier, can be included in the principlism described by Beauchamp and Childress. I will look especially at the principles of autonomy and beneficence and at how the stipulations of care ethics can effect the re-definition and specification of their content. With regard to autonomy, the ontology of interrelatedness (e.g., the postulation that we are essentially interconnected with others as opposed to radically individual,) and the recognition of emotions as a legitimate epistemological source will have particular bearing on the three conventional requirements of autonomy: 1) effective deliberation, 2) freedom from coercion and 3) adequate information. With regard to beneficence, the respect that care ethics encourages for interrelatedness and emotional involvement will significantly alter conceptions of patient good. Allowing for emotional vulnerability and other non-biological aspects of patient well-being to be regarded as relevant, the accepted definition of beneficence, or the good of the patient, which identifies physical cure as necessary, and sometimes even sufficient (Gadow, 1988:5; McFarlane, 16; Pepin, 1992:128; Wendell, 1993:234-235), will be revised. Emotional care and attentiveness to relationships of connectedness and/or vulnerability will deepen the understanding of the goals of health care professions.

In Chapter VI, I will look at care ethics' tenet of interdependence and at the importance it places on the professional/client relationship. These ideas impact the way an individual sees his or her autonomy and the way in which his or her beneficence can be interpreted. In addition, these concepts influence the moral relationships between health care professionals and their patients. Using Michael Bayles' descriptions of five different types of professional/client relations, I will examine the nature of the health care professional/patient relationship. I will argue against the distinction between personal and impersonal relations as a marker for dividing the considerations of care ethics from the considerations of justice ethics. Rather, I will argue that it is the nature of the professional/client relationship itself, in which vulnerability is natural or
institutionally imposed, which necessitates taking different kinds of moral considerations into account.

In Chapter VII, I will look at the compatibility between the methodology of care ethics and that of traditional philosophies. I will maintain that the stipulation of care ethics, which claims that context and particularity should be taken into account more in a different manner than is customary in moral decision-making, does not violate the requirements of universality and justice. In fact, I will suggest the reverse: that the requirement of universality necessitates the consideration of context and particularity insofar as these constitute morally relevant similarities and differences. In other words, the level of particularity deemed suitable for moral discrimination has traditionally excluded particularities which care ethics identifies as critical. I will contend that care ethics is justified in asserting that these particularities be given due consideration. Our differences in personality and context should not be suppressed in the name of equal treatment. With regard to the requirement of impartiality, I will argue that it is not breached by the inclusion of these particularities as long as similar considerations are made in similar circumstances. Attention to particularity does not entail favouritism or unjustified discrimination; in fact, it promotes justice.

The assumptions which will be debated in this chapter have led in the past to the assertion that the considerations of care ethics are necessarily subordinate to the considerations of justice theories. I will submit that this is a false hierarchalization and that the two kinds of theories can, at least in the context of care ethics and principlism, exist in harmony as Baier predicts. As long as principlism allows room for the kind of specification of its principles which the tenets of care ethics require, there is much potential for negotiation and partnership between the two moral approaches.
CHAPTER I

Modern History & Theoretical Evolution of Biomedical Ethics

Introduction

In order to comprehend and analyze the current theoretical climate in biomedical ethics, it is helpful to understand the historical developments which have influenced it during the past century. The beginning of this chapter examines how the focus of ethical concern has shifted over the previous one hundred years from a seemingly exclusive concentration on paternalistic beneficence, to a preoccupation with a set of principles, including, most notably, the principle of autonomy. This set of principles, which has developed into what are commonly referred to as the principles of biomedical ethics, or "principlism,"\(^3\) has been criticized on two main fronts. Chapter II will be devoted to a study of one cluster of these criticisms, whereas Chapter III will address the other.

The set of four principles which constitutes the main version of principlism has become the standard "mantra" of biomedical ethics. This quartet, endorsed primarily by Tom L. Beauchamp and James F. Childress in their text, Principles of Biomedical Ethics, identifies the primary principles as autonomy, beneficence, non-maleficence and justice. This model of biomedical ethics has come under scrutiny from two main perspectives. On the one hand, those represented by Danner K. Clouser, Bernard Gert and Ronald M. Green, argue that principlism is not theoretical enough because it is not governed by an authoritative theoretical structure which adjudicates among the four principles. Principlism, according to these critics, is an \textit{ad hoc} mixture of principles from different, and inherently contradictory theories, such as Millsian

\(^3\) The term "principlism" is considered by Beauchamp and Childress to be "disparaging" (Beauchamp & Childress, 1995:21) due to the fact that it is used by K. Danner Clouser and Bernard Gert in their critical assessments of Beauchamp and Childress' four principles. In the writing of other authors, however, the term "principlism" is used in more objective contexts (Dubose, et. al. in A Matter of Principles). I use the term in an objective rather than a critical manner due in part to its recognizability in the literature, and in part to its simplicity over Beauchamp and Childress' preferred term, "the four-principles approach" (Beauchamp & Childress, 1995:21).
utilitarianism and Kantian deontology. Clouser, Gert and Green claim that it is absurd to put them in the same company without assigning them their hierarchical status.

On the other hand, critics represented by philosophers such as Henk ten Have, Pinit Ratanakul, Richard M. Zaner and James F. Drane, argue that most versions of principlism are too theoretical. They reject the claim that the principles endorsed by principlism can be defined and ranked a priori. They challenge the assumption that we can abstractly determine the meaning of, for instance, the term "autonomy," and that we could claim, for example, that considerations of autonomy necessarily and categorically trump all others. Employing anti-theoretical tactics, they suggest that such definition and prioritization of principles must occur on a more fundamental, social and experiential level. Consequently, from the perspective of European deontology, phenomenology and hermeneutics, principlism must become more connected with experience and context, and less abstract and alienated from life.

What these criticisms of principlism demonstrate is that within the discourse surrounding biomedical ethics, a healthy debate is already in progress. Biomedical ethics has not been unanimously established as the application of abstractly defined, hierarchically ranked principles to dilemmatic situations. On the contrary, its main proponents are responding much more favourably to the critiques of those on the more anti-theoretical side of the debate. In James F. Childress's *apologia* for Beauchamp's and his version of principlism, (Childress, 1994) he refutes the criticisms of Clouser, Gert and Green, and tries to demonstrate principlism's hospitality to the suggestions of more empirically oriented critics.

The first three chapters of this thesis will set the stage for an analysis of the criticisms and substantive contributions of proponents of care ethics. After examining the discussion which is already in progress among supporters of biomedical ethics, we will be able to examine how, if at all, the criticisms of care theorists differ from those postulated by the anti-theorists against principlism. Clearly, those who support care ethics will disagree substantially with the arguments of authors such as Clouser, Gert and Green, who promote abstraction, hierarchy and dogmatic universality. It is not so clear, however, that the criticisms expressed in care ethics differ substantially from those on the anti-theoretical side of the debate. In fact, it may be the case that proponents of care theory are misdirecting their criticisms entirely, if indeed, as is the case with some, they envision biomedical ethics to be ruled by an overarching, absolute,
authoritarian theory. It is to these questions that I will turn after Chapters I, II and III.

In this chapter I will outline a chronological history of principlism beginning with a review of the renaissance of biomedical ethics which took place a quarter of a century ago. I will then describe the notable shift of focus which occurred when the demand for patient rights broke the monopoly of paternalistic beneficence. In the following section, I will explain how the need for justice became paramount in response both to overwhelming patient demands (in accordance with autonomy) and to simultaneous scarcities of medical provisions and technologies. Finally, I will discuss another historical account, promoted by David J. Rothman, which concentrates on the socio-cultural factors which precipitated the recent developments in biomedical ethics.

**The Renaissance of Biomedical Ethics**

It is said that biomedical ethics enjoyed a renaissance approximately twenty-five years ago (Clouser & Kopelman, 1990:123). Its rebirth is often anecdotally attributed to the revolution in medical technology which empowered physicians technically, but overpowered them morally. Questions on how to deal with new high-tech equipment and complex procedures needed to be answered. Hence the attempt by philosophers to draw upon ethical theory to solve medical dilemmas.

This explanation for the recent revival of biomedical ethics is correct yet incomplete. It cannot account fully for the developments in ethical thought which emerged as a result of the collaboration between philosophy and medical issues. A more thorough report explains how the principles which justified medical practice rapidly metamorphosed into the version of biomedical ethics which is currently popular. I will now turn to a summary of some of the significant events in recent history which influenced the development of biomedical ethics.

The availability of new technology was not the only catalyst in the re-creation of biomedical ethics: it was the manner in which some of this technology was initially employed which necessitated the intervention of ethical discourse. After the atrocities committed in the name of science against prisoners during the Second World War, the Nuremberg Code was drafted (Faden & Beauchamp, 1986:153). Derived from the case, *United States v. Karl Brandt*
in 1948, the code’s primary requirement was the voluntary consent of the research subject. Fourteen years later, in 1962, the World Medical Association (WMA) produced the Declaration of Helsinki in order to rectify the Nuremberg Code which had since proven inadequate to deal with the growing number and complexity of biomedical cases. In the Helsinkin Declaration, informed consent was once again an absolute requirement for experimental research. For therapeutic treatment, however, it was not required, ostensibly due to the fact that beneficence-based premises supported the "physician’s therapeutic privilege in medical practice" (Faden & Beauchamp, 1986:156). Historically, the Declaration became a rallying point and a blueprint for several medical associations and future codes of research ethics. Among these were the American Medical Association (AMA), the America Society for Clinical Investigation, the American Federation for Clinical Research, as well as federal agencies in the United States (Faden & Beauchamp, 1986:157).

Despite the fact that the Nuremberg Code and the Helsinki Declaration were established in reaction to intolerable experimentation, they were ineffective in putting an end to experimental horrors. In 1966 Henry Beecher published a report in The New England Journal of Medicine on the unabashedly unethical research practices being funded by the government of the United States. They included the replacement of Mexican-American women’s birth control pills with placebos, and the intentional injection of cancer cells into terminally ill patients (Veatch, 1987:2). Later the same year, Beecher published an essay in the Journal of the American Medical Association which cited the research of M.H. Pappworth, an Englishman who had collected more than 500 papers involving non-beneficial experiments performed on newborn infants, children, pregnant women, surgery patients, the mentally handicapped and the dying, in the absence of their consent (Faden & Beauchamp, 1986:159).

Clearly, the temptation to discover and experiment with new medical technology was not the only, or even the main, reason for the rapid growth of biomedical ethics. Its expansion was due to the fact that the ways in which such discoveries and experiments occurred did not preclude the abuse of experimental subjects. Morally, this meant that standards in biomedicine did not adequately protect the rights of the individuals on whom suspect procedures were carried out. The criterion which had supposedly guided physicians in the past was the principle of beneficence, the duty to help and promote the welfare of the patient in question. Until the
mid-twentieth century, the beneficence model was the only guide physicians used to determine their responsibilities to their patients (Faden & Beauchamp, 1986:100). Although cases such as those committed during World War II clearly violated the standard of beneficence, even those which adhered to it in theory were often suspect in practice. In other words, the principle of beneficence was easily mistranslated into considerations of utility - e.g., abuse of the particular patient for the good of science in general. Even in less extreme cases, following the principle of beneficence alone, researchers could easily make biased decisions regarding the ratio of benefit to risk which was considered tolerable for experimentation, could practice benevolent deception for nondisclosure and could benevolently deceive patients into giving consent (Faden & Beauchamp, 1986:76). Furthermore, from a deontological perspective, the very fact that such experimentation was done without patients’ knowledge was considered inherently wrong, due to the fact that it prevented patients from exercising their autonomy, which was considered inherently valuable.

A Shift in Theoretical Perspective: Beneficence to Autonomy

Edinburgh student Thomas Percival (1740-1804) drafted his chef d’oeuvre, Medical Ethics, in 1803. This work served as the standard beneficence model for physician-patient relations until the Second World War (Faden & Beauchamp, 1986:60). It provided the basis for the first Code of Medical Ethics documented by the American Medical Association in 1847, and remained virtually unchanged until the 1950s. After the brutalities of World War II, popular interest in legal rights to self-determination and increased philosophical interest in the principles of autonomy and individualism (inspired by the various social and civil rights movements of the era,) contributed to the gradual metamorphosis of medical standards (Faden & Beauchamp, 1986:70). Several court cases furthered the cause of self-determination, the earliest of which was Schloendorff v. Society of New York Hospitals (1914) in which it was ruled that "every human being of adult years and sound mind has a right to determine what shall be done with his own body" (Faden & Beauchamp, 1986:173). The right to self-determination became the justification for informed consent. Consequently, in 1957 another landmark case, Salgo v. Leland Stanford Jr. University Board of Trustees, resulted in the duty
to disclose "any facts which are necessary to form the basis of an intelligent consent by the patient to proposed treatment" (Faden & Beauchamp, 1986:125). A series of critical cases followed these in 1972, including *Canterbury v. Spence*, *Cobbs v. Grant* and *Wilkinson v. Vesey*, all of which helped modify and clarify the terms of informed consent (Faden & Beauchamp, 1986:132-138).

The first references to "informed consent" in medical literature appeared in issues of *American Medicine* in the late 1950s and 1960s. Shortly thereafter, in 1969, the concept of informed consent became couched in the language of rights. This development occurred when the American Joint Commissions on Accreditation of Hospitals issued a revised policy statement. Various consumer groups reviewed the statement and were alarmed by the lack of references to the interests of patients. One of the groups concerned was the National Welfare Rights Organization, which suggested twenty-six proposals for the rights of patients, a proposition which is hailed as the genesis of the patients' rights movement. Some of their proposals were adopted by the Joint Commission on Accreditation of Hospitals. However, they received even more attention from the American Hospital Association which adopted "A Patient's Bill of Rights" in 1972. This Bill became the keystone for the development of the autonomy model in medical practice (Faden & Beauchamp, 1986:94).

**The Urgency of Justice**

Despite a shift from reliance on the principle of beneficence to an overwhelming endorsement of rights and entitlements in health care, there was still the need to balance the needs of the individual against those of other particular individuals, as well as against those of society. This was not a utilitarian question of how to benefit the greatest number. Rather, it was an issue of how to balance the needs of everyone simultaneously, i.e., without violating the needs of any one particular individual. With increased technological power, with the ability to perform more miraculous resuscitations on, and cures for what would, a few years earlier, have been terminally diseased patients, the pressure to provide such miracles to everyone who "needed" them developed into a veritable crisis of resource allocation.

In his article, "The Birth of Bioethics," Albert R. Jonsen refers to the dialysis events of
the 1960s as another catalyst, which in conjunction with Beecher’s expositions, provided the momentum for the re-evaluation of North American medical ethics (Jonsen, 1993:S2). The dialysis events involved the innovative research of Seattle’s Dr. Belding Scribner, who had invented a dialysis method referred to as the "arteriovenous shunt and cannula" in 1961. The technique was hailed as life-saving, and due to its recent invention and the fact that it had not been massively reproduced, was in very high demand. Being a "limited resource," there needed to be some method for its just distribution. The question of who should live and who should die, had to be answered.

In response to this crisis, a review group was formed. Interestingly, and a sign of the times, this group was formed primarily of "outsiders," or lay people, rather than of physicians and medical experts (Jonsen, 1993:S1). The group, which was referred to informally as a "God Squad," was asked to review the files of the candidates for dialysis, and to make admittance decisions on the basis of certain criteria (Life magazine, 1962). It was the choice of criteria on which to base these decisions that was the harrowing task. On what basis could one person’s interests be subordinated to another’s?

In David J. Rothman’s assessment of the events surrounding the dialysis crisis, the shift of decision-making from the hands of doctors to the will of the people was highly significant in the philosophical trend away from beneficence. As Rothman points out, "physicians turned to a lay committee because they realized that the traditional medical ethic of each doctor doing everything possible to enhance the well-being of the particular patient could not operate in these circumstances" (Rothman, 1991:151). Thus even in the absence of malicious intent, as was the case in a number of the events cited in Beecher’s reports, the reliance on beneficence was not sufficient. Reliance on a handful of people, however, also turned out to be insufficient in the eyes of society. The criteria upon which the Seattle committee based its decisions seemed to be arbitrary and discriminatory. A more concrete, coherent, just system of allocation was called for. As Rothman puts it, there was a "need to construct principles or guidelines to make certain that medical decision-making represented more than the accumulated prejudices of a handful of people, whether their training was medical or not" (Rothman, 1991:152).
In his account of the modern history of biomedical ethics, Robert M. Veatch chronicles the theoretical evolution connected with the events surrounding and following the trials of Second World War criminals. Veatch explains that the prosecutors at the Nuremberg trials had two options. Either they could supplement the beneficence approach to patients by insisting that experimental research only be done in the likelihood of patient benefit, or they could support the beneficence thesis with another principle entirely. As the legal history testifies, the second option was chosen and the principle of autonomy was asserted in the medical sphere both to ensure beneficial treatment and to limit paternalistic beneficence (Veatch, 1987:23-24). This route was chosen in accordance with the rule utilitarian argument that respect for autonomy is a rule which in general results in the greatest benefit for the greatest number, and in accordance with the deontological doctrine in which autonomy is valued on the basis of its intrinsic worth.

A common reference point for theoretical development in biomedical ethics are the deliberations of the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, which took place during the 1970s. In Ethics and the Regulation of Clinical Research (1986), Robert J. Levine discloses the theoretical assumptions behind the work of the Commission. The first assumption he lists is the claim that "both utilitarian and deontological reasoning have a place in ethical decision-making" (Levine, p.11). In other words, the Commission did not decide exclusively to endorse either the older, utilitarian-based beneficence model of biomedical ethics, or the relatively new deontologically-based autonomy model. Rather, as M.B. Abram and S.M. Wolf comment, although the Commission was aware of Kantian (deontological), utilitarian, and Aristotelian traditions, it "nonetheless refrained from relying on any one of them for the legitimacy of its [the Commission's] conclusions" (Abram & Wolf, 1984). Furthermore, in Abram's and Wolf's commentary, the Commission claimed that "agreement on a fundamental moral system was not sought or needed" (Levine, 1986:11).

The model which the Commission adopted for its reports was one which begins with basic ethical principles from which ethical norms and then specific requirements, are deduced. There are three basic ethical principles which the Commission endorsed: 1) autonomy, 2)
beneficence and 3) justice. Rather than follow the recommendations of philosophers who argue that there should be a single super-principle, such as justice or beneficence, and that any plurality of principles should at least be categorically ranked and prioritized, the Commission encouraged equality among its three principles and acknowledged the fact that the application of such principles would result in conflicting recommendations (Levine, 1986:12).

**An Alternative Historical Account**

I have already suggested that the exponential growth in industry and technology is not the exclusive, nor even the primary, reason for the necessity of protective regulations in the medical sphere. In the previous section, Beauchamp and Faden emphasize the effect of World War II and imply that it was the abuse of technology in perverted pseudo-scientific experimentation which catalyzed ethical discussion around biomedical issues (Beauchamp & Faden, 1986). This explanation also requires supplementation.

In another historical assessment of the past century of biomedical ethics, Rothman does not rely only on wartime atrocities to explain the subsequent mediation by "outsiders" between medicine and its patrons (Rothman, 1991:5). Rothman's analysis does not focus on a discrete historical event, but rather, on an ongoing historical effect. In his opinion, it is not the evils committed by scientific researchers during World War II which are the primary cause of ethical intervention. Rather, it is the continuing distance and distrust which this abuse has necessarily put between doctors and patients which accounts for the ongoing need for biomedical ethics.

The connection between doctors and patients eroded not only because of the mistrust instilled in people by the atrocities of World War II. It was also a function of the expansion of medical technology and expertise. By the expansion of technology, I am not referring to the necessity which technology created to answer god-like questions of whether to promote life or

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4 In this discussion, the use of the term "doctor," as opposed to "health care professional," is used by Rothman. Rather than render it more inclusive, I will use it specifically in order to emphasize that it was the doctor-patient relationship, and not that between the patient and other health care professionals, such as nurses, which eroded. Rothman does not give this justification for his use of the term, and indeed, never even refers to the relationship of the patient to other health care professionals.
to allow death, which we previously did not have the need to address. Rather, I am referring to the fact that technology, rather than the patient, became the doctor’s priority. As Rothman explains,

[H]ad other considerations not intervened, one could imagine trusting the expert in technology to determine the appropriate use of the technology. Why not let those who are able to defy death be the ones to define death? In short, costs and technology are highly relevant to the new posture toward medicine and medical decision making, but they alone cannot explain it. Indeed, an erosion of trust may well have been a precondition for economic and technological regulation. It was because doctors were strangers that they could not be trusted with the respirator. It was because hospitals were strange institutions that their costs and practices had to be monitored (Rothman, 1991:13).

Rather than locating the initiation of modern biomedical ethics at the end of World War II, Rothman points to the decade between 1966 and 1976. He identifies Henry Beecher’s exposition of American abuses of human experimentation as the moment at which biomedical ethics was reborn. This riveting event, followed some years later, in 1973, by the appointment by the U.S. Congress of Senators Walter Mondale and Edward Kennedy to lead the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, signalled the shift from the internal to the external government of ethics in medicine (Rothman, 1991:3).

What is significant about Rothman’s focus on Beecher’s exposition is that it testifies to the loss of trust in the researcher-subject relationship. Whereas other theories emphasize the misuse of power by the powerful, Rothman’s analysis underlines the change which this abuse fostered in the relationship between researcher and subject. Rothman explains that his analysis looks at the metamorphosis that occurred during the decades following World War II. The social space between doctor and patient, as well as between the hospital and the community became too large. There was no longer a sense that there were values which were shared by those both within and those beyond the medical sphere. In the absence of trust based on shared interests, and in the face of the fear of conflicting interests between the medical and the medically-dependent worlds, there was a perceived need to grasp for rules and regulations in order to maintain some sense of security and safety. As Rothman succinctly puts it, "bedside ethics gave way to bioethics" (Rothman, 1991:11, 126).
Before World War II, the intimacy shared by doctors and their patients generally meant that there was no perceived need for artificial, rigid guidelines for treatment. In times when communities were smaller, and family members still had strong personal bonds with their family doctors, physicians knew their clients and their ailments well enough, and their clients had enough trust in them, that regulations were unnecessary. Rothman recounts Oliver Wendell Holmes' comment that "doctors were capable of substituting their judgment for that of their patients...because they intuited their patients' wishes." This was due to the fact that doctors "knew their patients' families dead and alive, up and down for generations" (Holmes, 1891:377). After both World War II and Beecher's exposition, not only did trust necessarily erode, but science became highly interested in large scale research. The exigencies of the war had necessitated the abdication of individual interests and personal rights in the name of the common good. Such measures as the draft, forced military duty, assignment to combat, and so on, had familiarized the popular culture with teleological, as opposed to deontological, perspectives on morality (Rothman, 1991:49-50). The military attitude, or campaign mentality, as Rothman refers to it, became the ethos not only of war, but also of the laboratory. It was this mentality that allowed unacceptable experimentation for dysentery, malaria, and influenza to be performed on the mentally retarded, the mentally ill, prisoners, ward patients, and medical students without their informed consent (Rothman, 1991:48).

The familiarity with, and acceptance of, such utilitarian calculations and procedures during World War II did not subside with the cessation of the war. Although at first glance, the continuation of the desire to obtain quick and progressive scientific results seems an unwelcome and often unacceptable phenomenon, it is understandable. Like women, who tasted a kind of freedom and sense of independence in the work force during the war years which they never forgot, so scientists and researchers were exposed to the thrill of working at top speed with few restraints. This is evidenced in Rothman's citation of the report issued by the National Society for Medical Research in 1959 which claimed,

The standards for health research on human subjects should recognize the imperative need for testing new procedures, materials and drugs on human subjects as essential to the public interest. The protection of personal rights of individuals...can co-exist with the public necessity to use people - sick or well - as subjects for health research (National Society for Medical Research, 1959:81).
According to Rothman, the lust for spectacular breakthroughs, the potential for which had now been shown to be so great, was sufficient incentive to legitimize all methods of investigation (Rothman, 1991:53). Granted, lip-service was paid to patients’ and subjects’ integrity, but it was merely that. The National Institutes of Health claimed that the well-being of subjects came first: "[t]he welfare of the patient takes precedence over every other consideration" (Rothman, p.54). In conjunction with this, and other guidelines, however, there was no institution of formal mechanisms or regulations to enforce them.

In other words, the freedom and discretion which physicians enjoyed before the horrors which occurred during World War II were enjoyed even after its end, reinforced by wartime utilitarian ideology. One of the reasons for the continuation of this ideology without external controls, according to Rothman, was the fact that a misguided distinction was made between the events which occurred in wartime Europe and medical research in post war America. On the one hand, this distinction was based on the belief that, "madness, not medicine, was implicated at Nuremberg" (Rothman, 1991:63). On the other hand, and more importantly, there existed the perception that the atrocities of World War II were the result of government interference in the conduct of research.... Hence, state controls over medicine through regulations that intruded in the private relationship between doctor and patient or investigator and subject were likely to pervert medicine (Rothman, 1991:63).

The result of this unsupervised relationship between physician/researcher and patient/subject in light of the new utilitarian ideology of the post World War II era was made evident by the Beecher files. In response to the scandalous conduct Beecher exposed, the National Institute of Health commented on "the inadequacy of our guidelines and procedures." One official stated that Beecher’s report "clearly brought to the fore the basic issue that in the setting in which the patient is involved in an experimental effort, the judgment of the investigator is not sufficient as a basis for reaching a conclusion concerning the ethical and moral set of questions in that relationship" (Frankel, 1972:20-21). Hence the need for external supervision.

The external players who were invited to try to create better enforcement regulations included lawyers, legislators, religious leaders and philosophers. Their common objective was
to bring new rules to medicine and, more specifically, to reduce physicians' discretion and authority in favour of patients' autonomy (Rothman, 1991:5). According to Rothman, almost all of these professionals immediately rejected the utilitarian framework adopted by researchers (Rothman, 1991:94). The only escape, some argued, from the dangers inherent in experimentation, was through "a revitalization of the principle of consent. Human subjects had to become their own protectors" (Rothman, 1991:98).

This philosophical approach meshed well with reformers' social principles inspired in the 1960s, which I referred to earlier in this chapter. The attempt to enforce the requirement of informed consent reflected a larger migration in social attitude which moved more and more towards securing personal rights rather than communal goods, thereby valuing the individual over the collective. In other words, an effort was made to replace the wartime, utilitarian ideology which had allowed the sacrifice of individual rights in the name of the nation.

The outcome of these trends included the instigation of the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, the results of which I have briefly alluded to, and the implications of which will be discussed again later in Chapter II. Significant in Rothman's account is the fact that the ethical principles and resulting regulations which the Commission's report endorsed and encouraged were articulated not only to limit physician's control over biomedical issues but also to put a band-aid on a wounded relationship between the medical establishment and its dependents. As Rothman puts it,

these events presumed a warfare between "them" and "us," in which self-serving motives were cloaked in the language of benevolence, and majorities took every occasion to exploit minorities. In such a combative world, one had to depend on rules, not sentiment, to secure fairness (Rothman, 1991:100).

A division along competitive lines had been drawn between physicians and researchers, and their respective patients and subjects. Whereas before World War II the language of benevolence was not a disguise for the exploitation of patients, it had now become one.

A brief historical review of the concept of beneficence reveals the evolution in its interpretation. In much earlier times, Maimonides (1125-1204), an important physician and philosopher, emphasized the imperative of treating patients as ends in themselves and never as a means to an end. Although this deontology did not necessarily entail the requirement of
respect for autonomy as it did in Kant’s second formulation of the categorical imperative, Maimonides’ beneficence nonetheless proscribed utilitarian sacrifice.

A century later, Roger Bacon (1214-1292) articulated his immense respect for the sanctity of the human being and the human body when he acknowledged that science could progress rapidly in nonhuman fields due to the ability of researchers to perform multiple control experiments to verify their results, but that human science would have to tolerate a slower rate of progress due to the fact that non-therapeutic experimentation could not be conducted.

Several centuries later in 1865, Claude Bernard, professor of medicine at the College of France, wrote that "the principle of medical and surgical morality consists in never performing on man an experiment which might be harmful to him to any extent, even though the result might be highly advantageous to science, i.e., to the health of others" (Bernard, 1927:101-102).

As medical science progressed, beneficence toward the individual metamorphosed into beneficence toward the many. In other words, individual integrity gave way to collective impunity. The paramount end or telos became not the person, but the people.

What Rothman’s arguments indicate is that as technology developed, the relationship between physician and patient was altered, resulting in a shift in focus from individual benefit to scientific progress. As he explains, "practically every development in medicine in the post World War II period distanced the physician and the hospital from the patient and the community, disrupting personal connections and severing bonds of trust" (Rothman, 1991:127). It was the loss of close and personal relationships which influenced the trend towards utilitarian thinking. Modern health care is arranged such that patients are almost inevitably treated by strangers in a strange place, at a time of crisis. This anonymity is responsible not only for the need for dependency on rules rather than on sentiment, as Rothman explained, but also for a wary, suspicious consumer attitude of patients towards doctors. Rather than feeling grateful and trusting, the patient feels demanding and nervous. And for the doctor, a businesslike attitude is imposed if not accepted as the status quo. As Rothman points out, "pausing by the bedside has come closer to being, diagnostically speaking, an indulgence, for the patient is frequently far less interesting and less revealing about his symptoms than the technology" (Rothman,
The loss of trust in shared values, sentiment and beneficent attitudes toward particular patients resulted in the need for external constraints. As we saw in Beauchamp's and Faden's account, the Patient Bill of Rights of 1973 played a leading role in establishing new limitations on physician discretion and new freedom for medical consumers. "Leading national professional organizations, responding to external pressures, were now adopting the language and concepts of rights to delineate medical obligations" (Rothman, 1991:147). This bill and the subsequent results of the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, were what inspired the philosophical participation in the clarification of principles of biomedical ethics, a further analysis of which we will undertake later. Of particular note in Rothman's account of these events is his conclusion that this commitment to patient autonomy presumed that the most critical problem in American medicine was the nature of this doctor-patient relationship and that, by implication, such issues as access to health care or the balance between disease prevention and treatment were of lesser import (Rothman, 1991:245).

Citing Renee C. Fox, a renowned sociologist, Rothman agrees that this claim testifies to the fact that "bioethics lacks a sociological imagination" (Fox, 1976). The interesting aspect of this comment is that some current critics would applaud bioethics for its concern for the relationship between physician and patient. If, as Rothman argues, it is the transformations in this relationship which necessitate reliance on rules and rights, a renewed focus on the nature of this relationship would, for critics of the developments in biomedical ethics, be a good thing. Regarding this apparent disagreement about the significance of the doctor/patient relationship, it is important to note that a renewed focus on this dyad must indeed include an examination of and enquiry into the "nature" of the physician/patient relationship, rather than merely myopic consideration and acceptance of the relationship as it currently exists (autonomy vs. paternalism) in the absence of its social context (autonomy vs. social justice). As we will see later, some critics make the related claim that it is our preoccupation with crisis, emergency and sensational issues such as euthanasia, the shortage of dialysis machines and transplant organs, to which the principles of biomedical ethics tend to guide our attention, that has
blinded us to less exciting social questions, including so-called "house-keeping" issues such as the appropriate nature of the relationship between care-giver and care-receiver (Warren, 1994:37).

**Conclusion**

Depending on what we take to be the primary issues in biomedical ethics, we will interpret Rothman’s conclusions differently, as we will see in the later chapters of this thesis. What is of significance here is the fact that Rothman locates the emergence of biomedical principles of ethics in the changed relationship between physician and patient, and as I will argue later, identifies this relationship as the locus for the resolution of current biomedical problems. Rothman’s analysis makes it plausible that a concentration of attention on aspects of biomedical ethics which cannot be captured by the analysis of the principles as they are currently defined, such as aspects of trust and vulnerability in the context of health care relations, may be a step in the direction of dealing with the phenomenon of strangers at the bedside. In turn, attempting to deal with the underlying issues which have made strangers (or even absentees) at the bedside, will help us to understand why the principles of biomedical ethics are defined as they are, and what can be done about the (in)appropriateness of their definition and application in light of principlism’s critics.

Rothman’s analysis is significant in light of the other analyses I reviewed. Historical reviews which focus on the necessity of principles in response to new ethical difficulties posed by powerful technologies, and in response to abuses of these powers, use the language of principles to rectify injustices. On the other hand, Rothman’s account looks more deeply into the psychological factors which induced the mistrust, which in turn induced reliance on the artificial guidance of abstract rules and regulations. Rothman’s account allows us to turn our attention away from the language of rights and duties and towards issues of interconnectedness, relationship and emotional and affective attitudes.

I have drawn our attention to diverse approaches to the history of biomedical ethics. Some of these focus on the abuse of power positions, and the exponential growth in technology and the thirst for scientific progress. Another, namely Rothman’s account, focuses on the nature
of the physician-patient relationship and the influences which caused its transformation. Despite their differences in explanation, however, all accounts agree that the principles of biomedical ethics emerged from the medical historical events over the past decades and that biomedical ethics constitutes a specific, identifiable set of principles: autonomy, beneficence, non-maleficence and justice. It is to a closer analysis of these principles and their proponents that I will now direct our attention.
In this chapter, I will look at one particular exposition of the principles of biomedical ethics. Promoted by Tom L. Beauchamp and James F. Childress in their editions of *Principles of Biomedical Ethics*, this version is the one most often drawn from in courses on biomedical ethics, and the one most often criticized academically. Known as "principlism," (although it is not the exclusive rendition of this title) it endorses the principles of autonomy, beneficence, nonmaleficence and justice.

What is specific to Beauchamp and Childress' conception of principlism is that it includes the processes of balancing and specification. Balancing is the process of deciding which principle has priority in a given situation. Specification refers to the process of determining the appropriate content of the principles themselves.

This version of ethical theory in biomedicine conflicts with more traditional accounts of theory construction which rely on rigid, hierarchical structures in which principles have their predetermined places. In specific response to Beauchamp and Childress' theoretical approach, K. Danner Clouser, Bernard Gert and Ronald M. Green argue that an ethical theory must be governed by an overarching concept, in the manner that utilitarianism is governed by the principle of utility, or Kantianism is governed by the categorical imperative. They maintain that an approach which endorses equality among its chosen principles cannot appropriately be designated a theory.

In the following pages, I will disagree with the contentions of these traditional theorists, and will support Beauchamp and Childress' approach.

**The Basic Principles**

A few years after the American Hospital Association adopted the Patient Bill of Rights
in 1973, the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research presented the results of its deliberations. As pointed out earlier, the Commission referred to three primary philosophical principles: autonomy, beneficence and justice. This group of principles became widely influential in the literature surrounding biomedical ethics. In the first edition of their book, *Principles of Biomedical Ethics*, Tom L. Beauchamp and James F. Childress devoted one chapter to each of the four biomedical principles they acknowledge, in corroboration with the earlier Commission reports. Beauchamp and Childress endorse the principles of autonomy, beneficence, non-maleficence and justice. Although Beauchamp and Childress differ from the Commission on how to employ the principles once they are specified, they agree with what they call "common morality" rather than with a single overarching theory. The four principles they promote derive from "considered judgments" or moral quandaries such as precedent-setting court cases like *Quinlan*. Such cases challenged the courts to develop a new set of substantive rules. The framework for these rules was formed by comparative case studies based on analogy and by testing hypotheses against accepted norms. Gradually, this process resulted in a "loose consensus" in ethical discourse regarding a framework for ethical decision-making. According to Beauchamp and Childress, to imply that there was a pre-existing analytical blueprint available merely to be applied to cases would be to falsify history. The principles of biomedical ethics arose out of ethical controversies, thus comprising "common morality," rather than being pre-formulated in an omniscient theory (Beauchamp & Childress, 1994:18).

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5 Non-maleficence makes a stronger but narrower claim than beneficence does. Non-maleficence claims that at the very least, we have obligations not to harm others. Beneficence claims that in addition to the obligation not to harm others, we sometimes have duties to benefit others. Non-maleficence has a passive, *laissez-faire* undertone. Beneficence is based on an active, some would say supererogatory ideology.

6 *Quinlan* is a case which began in 1975 involving a young woman, Karen Ann Quinlan, whose parents fought the courts to gain legal guardianship over her in order to remove her life-support system after she had entered into a persistent vegetative state. It was a case in which the traditional sanctity of life ethic threatened to trump all other considerations. The Quinlan family fought for autonomy as proxies for their daughter, in order to make a substituted judgment on her behalf. Karen finally died more than ten years after her coma began because of pneumonia which was not treated with antibiotics (Pence, 1990:3-24).
Endorsements of these four principles abound in the biomedical literature. Referring to the research of Beauchamp and Childress, Veatch does not doubt their claim that "contemporary theorists tend to be able to show considerable agreement on just what principles should be adopted." Veatch adds that despite divergences on certain approaches, most theories include: a principle of beneficence, often a principle of non-maleficence, a principle of autonomy (or a surrogate such as the principle of self-determination,) and a principle of justice (Veatch, 1987:25). Likewise, in Faden and Beauchamp’s history of informed consent, the authors refer to three moral principles which are relevant to their subject matter: autonomy, beneficence and justice. These principles provide them with a sufficiently comprehensive analytical framework through which to understand and evaluate moral dilemmas (Faden & Beauchamp, 1986:5).

In their account, Beauchamp and Childress do not attempt to give any "higher" justification for the principles they choose. On the one hand, they contend that we cannot justify every moral judgment in terms of another moral judgment without engaging in an infinite regress. The alternative to this approach is simply to "accept some judgments as justified without recourse to other judgments," and to use these judgments as a starting point (Beauchamp & Childress, 1994:24). On the other hand, they claim that the choice of these judgments is not arbitrary or relative. For instance, the choice of beneficence as a principle is due to the long-standing, professional obligation to provide medical benefits to patients. In other words, the considered judgment is made that the mandate of medicine includes the attempt to benefit the patient. Conversely, the hypothetical judgment that the mandate of medical practitioners is to increase their capitalistic gains would not be acceptable for the common morality.

In answer to the charge of relativity, Beauchamp and Childress respond that "the principles of the common morality are universal standards" (Beauchamp & Childress, 1994:100). Despite their universality, however, the content of these principles is not predetermined. Using what they refer to as "specifying," "balancing" and "reflective equilibrium," they can reform the content of the principles according to certain criteria (Beauchamp & Childress, 1994:23-37, 101). Beauchamp and Childress refer to this process as dialectical. They claim that there is a constant dialogue occurring between our theory and our experience: "We develop theories to illuminate experience and to determine what we ought to do, but we also use experience to test, corroborate and revise theories" (Beauchamp & Childress, 1994:23). Criticizing Kant, Hegel once suggested
that all "content and specification" in a living code of ethics had been replaced by abstractness in Kant’s account (Hegel, 1942:89-90, 106-107). Beauchamp and Childress state that: "if a principle lacks adequate specificity, it is empty and ineffectual....Abstract principles must be developed conceptually and shaped normatively to connect with concrete action-guides and practical judgments" (Beauchamp & Childress, 1994:28). Although they claim that all moral norms are subject to revision, specification and justification, Beauchamp and Childress make their case in favour of Hegel more strongly when they claim that there is a "constant need" for further content, and that "the complexity of the moral phenomena always outruns our ability to capture them in general norms" (Beauchamp & Childress, 1994:30).

In addition to being specified, the principles of biomedical ethics also need to be balanced. Whereas specification deals with the substantive development of the meaning and scope of norms, balancing refers to the relative weight norms possess. Some theorists avoid the need to balance principles by simply setting them up hierarchically in the first place, as in the Kantian distinction between perfect and imperfect duties (Kant, 1783), and in the Rawlsian primacy of the first principle of justice over the second (Rawls, 1971). Beauchamp and Childress, however, support the claim made by the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, that "ethical reasoning should begin with multiple basic ethical principles...each of which in the abstract has equal moral force" (Levine, 1986:12). Rather than endorsing hierarchical structures, Beauchamp and Childress use W.D. Ross' notions of *prima facie* and *actual* duties. Principles may prescribe conflicting courses of action which indicate several *prima facie* duties. In order to get out of a stalemate, however, it needs to be determined which *prima facie* duty or duties must become *actual*. To do this Ross does not rely on any prefabricated pattern, but rather, on the facts at hand. A "considered decision" is made by investigating analogous reasoning from precedent cases and judging its suitability for the current situation by use of sensible intuition.

In their volume, Beauchamp and Childress attempt to present the four principles they endorse and to support them with arguments indicating their coherence with other aspects of our moral life, including moral emotions, virtues, and rights. This web of norms and arguments, which must be constantly specified and balanced, is their moral theory. There is deliberately no
attempt to describe the highest good or to identify any omnipotent principle (Beauchamp & Childress, 1994:106).

Implicit in Beauchamp and Childress' understanding of moral theory is the concept of what John Rawls labelled "reflective equilibrium" (Rawls, 1971:48). The foundation of this notion is that principles cannot be identified and developed a priori, or in a vacuum. In other words, there is a constant reverberation between initial intuitive convictions and the web of coherent principles which is endorsed. In describing reflective equilibrium, Rawls explains that it is

a notion characteristic of the study of principles which govern actions shaped by self-examination. Moral philosophy is Socratic: we may want to change our present considered judgments once their regulative principles are brought to light. And we may want to do this even though these principles are a perfect fit. A knowledge of these principles may suggest further reflections that lead us to revise our judgments (Rawls, 1971:49).

Including the concept of reflective equilibrium as an essential aspect of moral theorizing supports the notion that theoretical construction is the ongoing pursuit of an ideal. This pursuit cannot continue without constant checking and balancing between theoretical frameworks and their relationship to established moral conceptions and intuitions. Neither the initial intuitions nor the first set of proposed principles is conclusive. Both are authoritative and informative in the process of establishing a theory. Rawls explains:

[w]e need to be tolerant of simplifications if they reveal and approximate the general outlines of our judgments. Objections by way of counterexamples are to be made with care, since these may tell us only what we know already, namely that our theory is wrong somewhere. The important thing is to find out how often and how far it is wrong. All theories are presumably mistaken in places (Rawls, 1971:52).

The flexibility inherent in Beauchamp and Childress' theoretical approach reflects Rawls' understanding of how moral theory is constructed. Balancing and specification allow the interplay between practice and theory, between intuition and theoretical abstraction, between sensitivity to context and impartialist universalism. This humility with regard to the primacy of theory over practice is particularly relevant to criticisms which are levelled at principlism from both sides, i.e., from those who value theory, and from those who promote the empirical aspect of theory construction.
The overview of the history and development of biomedical ethics presented in this section demonstrates a strong movement towards the acknowledgement of certain principles which can guide our action in moral dilemmas. In the works reviewed thus far, which reflect a significant cross-section of opinion in biomedical ethics,' no dogmatic attempt has been made to establish a single, absolute, universally applicable moral theory. (Although Beauchamp and Childress believe that the principles they identify are universally relevant, they nonetheless require that the principles be specified, a stipulation which negates generic universalizability.) The approach the cited authors take is informally referred to as "principlism" by various critical writers. For the sake of clarity in this paper, I will use this term to refer to approaches characterized by Beauchamp and Childress' conception, rather than using the latter's label, "common morality" (Beauchamp & Childress, 1994:100).

Challenging Principlism: The Proponents of Grand Theory

Despite its pervasiveness, principlism has avid opponents. Some of the most vocal include K. Danner Clouser and Bernard Gert. (Ronald M. Green also attacks principlism in ethics, as we will see shortly. Other critics of anti-theory in general, as opposed to of principlism in particular, include Richard Brandt, David Gauthier, Alan Gewirth, R.M. Hare and Thomas Nagel (Clarke & Simpson, 1989:2).)

In a critique of principlism, Clouser and Gert provide a dramatic rendition of principlism's characteristics:

Throughout the land, arising from the throngs of converts to bioethics awareness, there can be heard a mantra "...beneficence ...autonomy ...justice...." It is this ritual incantation in the face of biomedical dilemmas that beckons our inquiry (Clouser & Gert, 1990:219).

Clouser and Gert do not take issue with the principles which have been chosen, or with their

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7 In the review of many of the criticisms of modern biomedical ethics which will follow, it will become evident that Beauchamp and Childress' model of principlism is by far the primary target. Beauchamp and Childress' version of the principles of biomedical ethics has become the paradigm of principlism.
respective content. Rather, they argue against the very approach which biomedical ethicists have adopted. They claim that principlism is "mistaken about the nature of morality and is misleading as to the foundations of ethics. It misconceives both theory and practice" (Clouser & Gert, 1990:220).

Clouser and Gert make a distinction between principles in the sense that they are found in theories such as John Stuart Mill’s Utilitarianism (1861) and Rawls’ Theory of Justice. In these theories, principles are "effective summaries" of the theory itself. They are shorthand derivations from the theories that generated them. Principles in these and other theories, (e.g., Kantian deontology,) are derived from some primary belief or claim, such as ‘suffering is bad,’ (utilitarianism), ‘humans should never be used merely as means, and not at the same time as an end in themselves’ (Kant, 1783) or ‘principles should be chosen behind a veil of ignorance in order to prevent discrimination,’ (Rawls, 1971). The principles which follow from such statements, according to Clouser and Gert, never compete with one another (Clouser & Gert, 1990:222). If ambiguity does exist, it is dealt with by categorically ranking the principles as Kant does, or by specifying exactly what the relationship between them is, as Rawls does.

Clouser and Gert claim that, contrary to the way in which principles exist in the context of such hierarchical and categorical theories, the principles of biomedical ethics exist in a chaotic, incoherent and misleading manner. They explain that principlism often has two, three, or even four competing "principles" involved in a given case. This, they continue, is tantamount to employing two, three, or four conflicting moral theories to decide a case. As if this were not problem enough, Clouser and Gert add that rather than trying to work out the conflict, the directive in principlism is to pick whatever combination of principles one wants to in a given situation.

I agree with Clouser and Gert’s assertion that the four principles espoused by Beauchamp and Childress render an historical reflection of different ethical theories (Clouser & Gert, 1990:223). As Clouser and Gert correctly claim, the recognition of the principle of autonomy represents Kant’s preoccupation with respect for the person; the recognition of beneficence incorporates Mill’s and Bentham’s ideals of increasing the net amount of good; the inclusion of non-maleficence reflects the theory of Gert, and the use of the principle of justice derives from Rawls’ ideal of impartiality.
I disagree, however, with Clouser and Gert's assertion that the mandate of principlism is a mix and match game of ethics. The fundamental tenet of principlism is that there is something valid about all of these principles, and that ideally we should try to respect each one as much as possible. Contrary to the claim that some principles can be left out of the decision-making process at whim, principlism requires that attention be given initially to all of the principles it endorses at every decision-making juncture (although it may be concluded that only some of the principles are relevant in a given case).

Although Clouser and Gert claim that an inflexible, hierarchical structure should support the principles of a theory such that conflicts among the principles can be easily addressed, they do not give explanations for why this method is more epistemologically justifiable than is a method in which there is abstract equality among the principles, which translates into actual hierarchy in particular cases (Levine, 1986:11). They do claim that one of the criteria of a theory is its action-guiding capability, a statement with which Beauchamp and Childress heartily agree. Clouser and Gert suggest that principlism fails to meet this criterion, despite the fact that it appears to have the tools to do so. They explain that at best, the principles of biomedical ethics direct the agent to reflect upon the relevance of a specific principle to a particular case. More likely, they continue, the agent "is only deceiving himself if he believes that he has some useful guideline to apply" (Clouser & Gert, 1990:222). What is interesting about this claim is the subsequent criteria which Clouser and Gert propose for a moral theory:

An adequate theory should indicate what is relevant to the moral judgment. In formulating theory we start with particular moral judgments about which we are certain, and we abstract and formulate the relevant features of those cases to help us in turn to decide the unclear cases (Clouser & Gert, 1990:232).

This etymology of ethical theory differs from the theoretical models of Kant and Mill, theories which Clouser and Gert advocate by virtue of their construction, if not for their substantive content. In these systems, an ideal is asserted from which all principles and rules which promote it are derived. There is no reassessment of the theory from the point of view of actual moral experience. It appears, therefore, that the model which Clouser and Gert describe is surprisingly similar to the model which Beauchamp and Childress support. In its analogous approach, Clouser and Gert's model even approximates the case comparison method espoused by casuists, some of
whom loudly reject theory altogether (Jonsen & Toulmin, 1989). Yet even though Clouser and Gert appear to refute their own promotion of a top down approach to ethics, they do not imply that the theory they derive from moral judgments is subject to review and future deliberation once it has been established.

Another criterion which any theory should meet is relevance to moral experience. A theory which condones a caste system among its principles often does not correspond to moral experience. In any case, Clouser and Gert give no reasons to demonstrate that such a system could reflect moral experience better than a Rossian⁸ or a principled system. Beauchamp and Childress refute Clouser’s and Gert’s assertions by arguing that any theory which does not need specification and balancing must be able to put enough detail and content into its norms to escape conflicts and dilemmas in all cases - a feat which they imply is impossible (Beauchamp & Childress, 1994:107). Rather than endorse an unattainable ideal of systematic unity in moral reasoning, Beauchamp and Childress accept disunity, conflict, and moral ambiguity as pervasive aspects of moral life.

Strangely, Clouser and Gert do seem sensitive to the failures of moral theories to live up to our moral experience when they refer to "historical examples of theories, e.g. those of Kant and Mill, which everyone recognizes as inadequate" (Clouser & Gert, 1990:232). In fact, they criticize Beauchamp and Childress for using the term "ethical theory" synonymously with failed attempts at grand-theorizing. The implication in Clouser and Gert’s comments is that all ethical theory does not need to fail as did Kant’s and Mill’s. If Beauchamp and Childress do endorse a "grand-theory" definition of ethical theory, it is no wonder that it plays no role for them in practical reasoning (Clouser & Gert, 1990:232). However, this is not the premise which Beauchamp and Childress use to refute grand scale ethical theories. Rather, as stated above, the

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⁸ W.D. Ross claims that there are no absolute, unconditional, a priori duties. He endorses seven principles from which prima facie, or potential, duties are derived. These include 1) fidelity, 2) reparation, 3) gratitude, 4) beneficence, 5) nonmaleficence, 6) justice, 7) self-improvement. In the absence of conflict among duties that arise from these principles, any one of them is imperative. In the case of conflict, the agent must make a "considered decision" or must use experience from previous cases to decide which duty is strongest in the particular situation. In other words, there is never any Clouser, Gert or Green-style hierarchy. Ross’ phrase, "prima facie duty" has been adopted in much of the discourse surrounding biomedical ethics to refer to approaches which do not promote grand-theory (Mappes & Zembaty, 1991:22-23).
impossibility of creating a static theory, and the incompatibility between the unitarian ideal of such a theory and the facts of moral life, form the basis of Beauchamp's and Childress' position. Furthermore, Clouser and Gert provide no examples of static, hierarchical theories which do not fail in guiding actions and adequately reflecting moral experience.

In addition to claiming that principlism offers no consistent explanation and justification for the relationship among its adopted principles, Clouser and Gert also state that principlism fails to critically evaluate the very principles themselves in terms of the theories from which they were derived. In the earlier editions of Principles of Biomedical Ethics (1979, 1984, 1989), from which Clouser and Gert draw their criticisms, it is true that a clear account of the reasons for endorsing the four principles of biomedical ethics is not given. In the last edition (1994), however, several theories and perspectives are outlined, critically examined, and constructively commented on. The strengths of each theory are highlighted, and the drawbacks are pointed out. In fact, the very reason for uniting theories such as those of autonomy and beneficence, instead of espousing a theory with one or the other of these principles as primary, is the fact that in isolation, these principles have the potential to violate other morally important criteria. Their relationship is explicitly facilitated because individually, these principles tend to do more harm than good. This very fact is the justification for their non-hierarchical union. The history of the development of biomedical ethics overviewed in Chapter I is a testament to this claim: the harms of an exclusively beneficence-oriented system had to be curtailed.

Ronald M. Green also criticizes the prevalent methodology in biomedical ethics using Beauchamp and Childress as a focal point. The basis of his criticism is the lack of "deep engagement with basic theoretical issues in ethical theory" (Green, 1990:188). Green uses Beauchamp and Childress' own disclaimer to prove his point. In the introduction to the fourth edition of Principles of Biomedical Ethics, (1994), Beauchamp and Childress distinguish metaethics from normative ethics and identify the latter as the locus of their treatise. This disclaimer, however, is only partially true due to the position Beauchamp and Childress take with regard to the etymology of ethical theory. If, as they claim, ethical theory arises out of moral experience and analogical reasoning, the presentation of an ethical theory is premature. Perhaps they should conclude their book with a section outlining the paradigms which have resulted from the balancing and specification of the principles with which they begin. Even if Beauchamp and
Childress truly wish to focus exclusively on normative theory, they are nonetheless engaging simultaneously in metaethics. As Green points out, the logical employment of moral terms and concepts and the analysis of the process of moral justification are so closely joined with normative ethics that the distinction between the two is thrown into question (Green, 1990:189).

Despite Green's emphasis on metaethics, what he thinks is necessary for a "deep engagement" with theoretical issues is fairly simplistic. He asks how it is possible to make progress in normative discussion without some procedure at hand for establishing priorities among principles. A hypothetical solution to this dilemma, he suggests, is to decide whether one espouses a utilitarian rather than a deontological position. The implicit assumption in this recommendation is that the endorsement of one or the other particular theory will clarify all points of contention. Even within a theory of autonomy or beneficence, however, there is ample room for disagreement which calls for further assessment. How autonomy is to be respected, what counts as autonomy, what is beneficial treatment, from whose perspective, etc., are all issues which the adoption of a particular ethical theory does not resolve. What Beauchamp and Childress are in effect doing, is metaethics at another level. They are clarifying the terms of, and justifications for principles, rather than the terms of and justifications for primary claims in super theories. In fact, in the fourth edition of their book, (1994), as opposed to in the second edition, (1983), which Green criticizes, Beauchamp and Childress state that they often do engage in metaethics, again clarifying, as Green does, that "no clear line should be drawn to distinguish normative ethics and metaethics" (Beauchamp & Childress, 1994:5).

To be fair to principlism's critics, I must acknowledge that attempts have been made by other principlists to organize and structure the principles they endorse such that a formulaic problem-solving calculus can be followed. Veatch, for instance, contends that the non-consequentialist principles of autonomy and justice outweigh the consequentialist ones of beneficence and non-maleficence. In the event of a contest between autonomy and justice, however, he maintains that justice takes priority (Childress, 1994:76-77).

H. Tristram Engelhardt, Jr., on the other hand, endorses only the principles of autonomy and beneficence, reducing the principle of justice to a function of these primary principles. In cases of conflict between autonomy and beneficence, Engelhardt assigns priority to autonomy (Engelhardt, 1986). From these examples we can see that by the very choice of which principles
are paramount and which are only derivative, priority is already established among some principles. Even Beauchamp and Childress’ model, in which they accept autonomy, non-maleficence, beneficence (including utility), and justice as primary principles, and veracity, fidelity, privacy and confidentiality as derivative rules, a hierarchy is set up. Whereas Ross accepts seven principles or duties as *prima facie* equal, Beauchamp and Childress do not (Childress, 1994:76). And the fact that Beauchamp and Childress endorse non-maleficence as well as beneficence, in contrast to the Commission’s support of beneficence only, also demonstrates a *prima facie* commitment to certain positions. The commitment to the principle of non-maleficence in addition to that of beneficence allows for more minimalist, or passive stances to be taken towards others. For instance, it allows for one to commit to the negative obligation of "doing no harm" as opposed to the positive position of "promoting good."

The choice of first principles does entail a commitment to a certain range of possible decisions; however, the kind of security and rigidity that Clouser, Gert and Green call for requires the kind of hierarchy that Veatch and Engelhardt reflect in their models of principlism. Beauchamp and Childress refuse to go this far. They do, however, acknowledge that their position on principlism has evolved over the years. In the first volume of *Principles of Biomedical Ethics* (1979), they concede that they were under the influence of a strong conception of ethical theory, based on foundationalism in moral justification. In corroboration with Clouser, Gert and Green’s position, they held that moral theories and principles were rooted in an ahistorical, *a priori* domain. In the third and fourth editions (1989, 1994), they shift their support to the postmodern, historicist position, and promote a coherentist belief in truth (Childress, 1994:74).

It is very significant that Beauchamp and Childress’ perspective has evolved over the years, deliberately away from the positions of writers such as Clouser, Gert and Green, and towards a version of ethical theory which uses "reflective equilibrium," construing "ethical inquiry as a matter of reflective testing of ethical beliefs against others or against particular ethical conceptions presented for exploration" (Clarke and Simpson, 1989:4). In addition to this shift which can be easily analyzed from a comparison of Beauchamp and Childress’ four editions of *Principles of Biomedical Ethics*, in Childress’ 1994 article, "Principles-Oriented Bioethics: An Analysis and Assessment from Within," he apologizes not to grand-theory critics, but rather, to
anti-theory critics, such as phenomenologists, virtue theorists and briefly, to feminist philosophers. In other words, Beauchamp and Childress’ model of ethical theory, hailed by many to be the definitive reference for study in biomedical ethics, is continuously trying to accommodate other positions by its reflective equilibrium, among them positions which openly reject any reliance on grand-theory at all. Beauchamp and Childress have effectively refuted and laid aside criticisms of grand-theorists and are moving more and more in the direction of phenomenological, hermeneutical and casuist approaches, among others. As Childress corroborates,

despite the major changes reflected in the...fourth edition of Principles of Biomedical Ethics, the framework is still recognizably principles-oriented, but it is, we believe, considerably enriched by our increased attention to method, emotions, virtues, care, relationships, all in response to major challenges to principles-oriented approaches to bioethics (Childress, 1994:72).

Conclusion

As the historical analysis presented in Chapter I reveals, the metamorphoses in biomedical ethics have led to the general espousal of four main principles: autonomy, beneficence, non-maleficence and justice. Theoretically, concern with rights and justice has led to a normative focus on the use of these principles and to justifications for their application. What the above arguments testify, however, is that there is a theoretical rift between two main approaches. On the one hand there are those, such as Clouser, Gert and Green, who believe that biomedical ethics is only a viable philosophical enterprise if it entails the derivation of hierarchical, categorical principles from a primary claim, which must be applied universally and impartially. On the other hand, there are those, such as Beauchamp and Childress and their anti-theory critics, who feel that the need for a single overriding primary claim followed by specifically and strictly related principles culminating in absolute rules and regulations is not necessary for a legitimate discussion of biomedical ethics.

Although I have summarily defended the latter thesis, represented by Beauchamp and Childress, the reason for presenting the distinction here is primarily to illustrate the current status of biomedical ethics. Despite the objections of those who disagree with principlism, Beauchamp
and Childress' model is what Clouser and Gert refer to as "a highly influential trend in biomedical ethics" (Clouser & Gert, 1990:220). Consequently, it is reasonable to conclude that the dominant model of biomedical ethics is principlism (Dubose et. al., 1994).

This analysis sets the stage for an investigation into the criticisms of the anti-theorists. What we must look at now is how well Beauchamp and Childress' principlism accommodates the positions posited by European deontology, phenomenology and hermeneutics. It has already been suggested that Beauchamp and Childress' model of principlism is more closely related to anti-theory than to grand-theory. We will see in the next chapter whether some of the anti-theorists' criticisms can be met. This analysis will position us well to investigate the claims of the ethical framework in which this thesis is primarily interested. Specifically, I will focus on the ethics of care, its history and its criticisms of dominant ethical frameworks. What the above exposition provides is a groundwork for assessing the criticisms of care ethics. Although the contentions of care ethics are clearly applicable to the type of theory promoted by Clouser, Gert and Green, it is not evident that they are well suited to principlism. Nor is it obvious that the complaints issued by proponents of care ethics differ substantially from the criticisms of those in favour of deontological, phenomenological and hermeneutical approaches. Let us now continue by clarifying the positions of the anti-theorists.
CHAPTER III

Anti-Theory and Beauchamp and Childress’ Principlism

Introduction

In this chapter, I will look at four anti-theory-based critiques of the general approach taken in North American biomedical ethics. The critics whose positions I discuss usually associate North American biomedical ethics with Beauchamp and Childress’ version of principlism as laid out in their Principles of Biomedical Ethics. As I will point out, however, there is sometimes discrepancy among the various editions of Beauchamp and Childress’ volume which are referred to, and consequently, there is confusion as to whether the current version of Beauchamp and Childress’ principlism is synonymous with the versions presented by other authors. As is clear from the earlier exposition of Beauchamp and Childress’ views, principlism has undergone important re-examinations over the years since its inception; consequently, which edition of Principles of Biomedical Ethics is cited makes a significant difference to the current relevance of the criticisms levelled at it.

The first of the four critiques I will direct our attention to is represented by Henk ten Have. He looks carefully at the differences between "U.S." theory in biomedical ethics, and compares it with what he calls "European deontology." He argues that bioethics cannot be seen merely as an application of pre-established principles, it is not something about which only experts can be informed, and its purpose is not merely to provide technical solutions to ethical dilemmas. Ten Have advocates an approach which includes historical perspectives, which is informed by the sociocultural context, and which maintains substantive normative viewpoints (i.e., the good over the right).

In the second critique, Pinit Ratanakul uses a Buddhist perspective to situate his commentary. Although he is fairly supportive of the need for principles, he agrees with ten Have that a substantive normative viewpoint is notably absent in principlism: Beauchamp and Childress, and the writers in their milieu, seem reluctant to make positive statements about what ethical norms society should endorse with regard to health care; rather, health care
discussions take place in the minimalist language of rights and entitlements (Ratanakul, 1994:124). Ratanakul also identifies the American trend to value the individual over the collective as dangerous. His solution to these concerns is to revisit the Buddhist notion of compassion, which, he explains, is not an emotion, but rather, is an attitude and perspective towards the world. Compassion is an umbrella notion from which principles can be generated.

The third set of critical arguments I will examine are generated by Richard M. Zaner. He argues from a phenomenological point of view and maintains that much more attention must be paid to contextual analysis and to the nature of the relationship between the physician and the patient. Ethical dilemmas cannot be solved in the abstract by the identification of principles and calculations by which to balance them.

Finally, I will turn to the comments of James F. Drane, who takes the position of a virtue theorist. He argues that principles cannot govern our actions. Principles are too thin to account for the range of situations and responses an individual must encounter in moral situations. Drane believes that we need to return to a discussion of the importance of character and virtues if we are to help biomedical ethics deal more adequately with the dilemmas it encounters - a reliance on principles is doomed to fail.

Beauchamp and Childress reject the criticisms of grand-theorists Clouser, Gert and Green, and claim that their version of principlism relies on reflective equilibrium rather than on *a priori*, ahistorical, foundationalist theory. Exactly how far, however, does Beauchamp and Childress’ principlism veer away from abstraction and universalism? Can their principlism meet the criticisms of those in the opposite camp, the anti-theorists, the phenomenologists, the virtue theorists, and ultimately, the care theorists?

**A European Deontological Criticism of the Principles of Biomedical Ethics**

In Henk ten Have’s critical evaluation of principlism, he compares and contrasts the dominant form of biomedical ethics which has arisen in North America with characteristics of European biomedical ethics. One distinction between the approaches of the two continents is that in America, health care dilemmas are dealt with more analytically and from a more applied approach (ten Have, 1994:103). In specific, ten Have refers to Beauchamp and Childress’
"well-known textbook" in which the authors define biomedical ethics as "the application of
general ethical theories, principles and rules to problems of therapeutic practice, health care
delivery, and medical and biological research" (Beauchamp & Childress, 1983:ix-x). Ten
Have's criticism of this approach is that it presupposes: 1) that bioethics is merely the
application of ethical theory and principles; 2) that there exist ethical theories and principles
to apply; 3) that biomedical ethics requires experts; 4) that biomedical ethics is the application
of general ethics to medical dilemmas and 5) that the purpose of biomedical ethics is to
provide practical solutions and prescriptions deduced from ethical theories and principles (ten
Have, 1994:105).

A response to the first two, and the last, of these assumptions, as well as to ten Have's
quotation from Beauchamp and Childress' definition of biomedical ethics can be made
immediately. In Childress' apology for Beauchamp's and his version of principlism, he clearly
acknowledges that "although Principles of Biomedical Ethics has used the metaphor of
application, as in "applied ethics," this was a mistake that misled some readers, as did its charts
that sometimes appeared to indicate a top-down approach through a process of justification"
(Childress, 1994:81). Later he adds that "particular moral judgments have relative independence
and can lead to a modification or reformulation of general principles; for example we note that
it is a mistake to say that ethical theory and principles are 'not drawn from cases but only
applied to cases' [Beauchamp & Childress, 1989:16]" (Childress, 1994:87). In the latest edition
of Principles of Biomedical Ethics (1994), Beauchamp and Childress specifically rename their
approach "practical ethics" rather than "applied ethics," adding the comment that the latter term
is misleading (Beauchamp & Childress, 1994:4). From the explanations already given from
Childress, (1994), and from the fourth edition of Beauchamp and Childress' Principles of
Biomedical Ethics, (1994), it is evident that, even if the adoption of new terms indicates an
earlier position which the authors held rather than a mistake (Beauchamp & Childress, 1979:9),
it nevertheless also demonstrates that Beauchamp and Childress have rethought their
perspective on the status of ethical principles. However, Childress concedes that although there
are few principlists who endorse a mechanical view of the application of biomedical principles,
there are some advocates of absolutist ethical theory (Childress, 1994:81,83).

Although Beauchamp and Childress can be defended from the specific charges ten Have
makes against their theory, they are not so immune to those of ten Have's criticisms which are based on more fundamental propositions. Ten Have explains that the presumptions inherent in Beauchamp and Childress' conception of biomedical ethics reflect a particular understanding of what ethics is. He quotes from deBeaufort and Dupuis (1988:19-20) who provide four criteria for an ethical theory to fulfil: 1) clarification of concepts, 2) analysis and structure of arguments, 3) balancing alternatives and 4) prescribing action (ten Have, 1994:105). It is only recently, he continues, that these foundational assumptions have been critically assessed. One criticism challenges the notion that biomedical ethics should serve primarily as a problem solving mechanism. Ten Have's position, for which he credits Baruch A. Brody (1988), supports my earlier arguments against Clouser and Gert in which I claimed that the existence of an all-encompassing theoretical umbrella does not necessarily protect us from conflicting ethical prescriptions. Ten Have takes this argument further, and even applies it to the kind of principlism that Beauchamp and Childress endorse, which, as we have seen, rejects the demand for grand-theory. Paraphrasing Annette Baier (1985), ten Have points out that the contention that any particular action can be supported by a particular biomedical principle encourages the idea in medical students and health care professionals that whatever course of action one takes in a dilemmatic situation, it will be justified by one principle, yet proscribed by another (ten Have, 1994:106). In a later paper, Baier refers to "the advance of a new breed of professionals, namely all those who assemble all the available theories, then "apply" them to suit their clients' needs" (Baier, 1989:37).

I agree with ten Have's claim that it is idealistic to expect to be able to come up with principles which allow for unproblematic solutions to biomedical dilemmas. However, Baier's claim that principlism simultaneously endorses and condemns all actions is not completely relevant to Beauchamp and Childress' position, as ten Have implies it to be. To hold Baier's position, which we heard echoed earlier by Clouser and Gert, is to assume that there is no inherent conflict among different goods. Conflicts among principles of biomedical ethics occur due to the effort, for instance, to simultaneously promote the autonomy of the patient, and protect him or her from physical danger; or to simultaneously promote individual health and welfare, and equitably distribute limited resources to everyone. Of course, depending on one's political or moral position, whether one is more libertarian than paternalistic, or more socialist
than capitalist, one will favour one principle more than another. So yes, in that sense, Baier’s comments are correct, although inappropriately critical. But Beauchamp and Childress’ principlism does not promote the idea that one is at liberty to use a certain principle in one instance without regard to the others. Balancing principles is always imperative.

What is interesting about Baier’s remarks is that, even though ten Have seems to use them to support his point with regard to an obsession with pseudo-problem solving techniques (i.e., claim 4) above), they ultimately suggest that principlism does not offer a sufficiently clear, uncontradictory conclusion, unconditionally supported by all its endorsed principles. Baier appears to worry about the dichotomous prescriptions which principlism imposes on those involved in biomedical dilemmas. Beauchamp and Childress, however, respond directly to ten Have’s criticism by referring to their two main ethical techniques, specification and balancing. They explain that,

as with specification, the process of balancing cannot be rigidly dictated by some formulaic "method" in ethical theory. The model of balancing will satisfy neither those who seek clear-cut, specific guidance about what one ought to do in particular cases nor those who believe in a lexical or serial ranking of principles, with automatic overriding conditions (Beauchamp & Childress, 1994:37).

Although Baier’s remark with regard to the misguidance of principles tends, ironically, to reflect Clouser and Gert’s earlier complaints, ten Have’s solution to the dilemma it points out is diametrically opposed to that proposed by Clouser and Gert. Whereas the latter suggested more theoretical authority and abstract hierarchy, ten Have emphasizes techniques characteristic of a more European approach to biomedical ethics: 1) the historical perspective on ethical issues, 2) the sociocultural context, 3) substantive normative viewpoints and 4) a philosophical approach to moral problems (ten Have, 1994:112). We already reviewed Childress’ defense of Beauchamp’s and his position on historicism in which he points out the shift in their approach from abstract, ahistorical foundationalism to contextual, historical coherentism (Childress, 1994:74). How much this shift in perspective allows for the inclusion of sociocultural elements is unclear. Nothing in Beauchamp and Childress’ position, however, necessarily precludes this from being the case. In fact, Beauchamp and Childress’ inclusion of techniques of reflective equilibrium necessitates reference to and examination of socio-cultural information.
Concerning the third characteristic of the predominant European approach to biomedical ethics, namely, substantive moral viewpoints, ten Have suggests that the obsession with procedure he identifies in North American biomedical ethics is insufficient. He asks how such issues as scarce resource allocation can be decided without substantial ideas on essential or adequate care. He asks how decisions can be made on such matters in the absence of a conception of health and human life, and in the absence of a politics of the good. He describes our ethics as thin and unsatisfactory, and offers the ethics of care as a viable alternative (ten Have, 1994:114). I think ten Have's criticism can be modified. Considering the modern history of biomedical ethics, it is evident that the shift from a reliance on the principle of beneficence to an assertion of the principle of autonomy, and with it the necessity of a principle of justice in order to balance the claims of the individual with the claims of the many, reflects a conception of the good. For whatever reasons, be they wartime atrocities, diminished trust in personal relations with professionals, disillusionment with medical technology, or a combination of several factors, the truth remains that in North America, the politics of the good adhered to is one that asserts the rights of the individual as much as possible without sacrificing the public good. There are limits to libertarianism insofar as paternalistic laws (generally of soft persuasion) exist to protect us from our own ignorance or folly. Nevertheless, the dominant philosophy (in theory if not in fact) of the northern half of this continent is one of liberal democracy, with the emphasis on the liberal, as opposed to the democratic, side of the equation. In other words, the principles espoused in Beauchamp and Childress' conception of biomedical ethics, as well as the principles advocated in other versions of principlism, such as Veatch's and Engelhardt's, reflect a North American view of what goods ought to be promoted. Ten Have even acknowledges the existence of a conception of the good in his reference to American culture in which "'good' is a matter more of personal than of collective concern" (ten Have, 1994:124).

Despite my contention that ten Have's criticism is somewhat misguided and self-
contradictory, I agree that proponents of principlism must nonetheless ask themselves if the conception of morality which their principles represent reflects, as ten Have puts it, "the kind of society we want" (ten Have, 1994:114). Do the principles which principlists choose adequately embody the values we wish to espouse? Should other principles be included in principlism? Or can the principles which principlism endorses, namely autonomy, beneficence, non-maleficence and justice, be specified in such a way as to include broader and more profound substantial concerns? These are questions which I will answer in more detail later in this thesis, especially with regard to the claims of care theorists. Suffice it to say for now that a model that endorses principles which serve to guide us and help us evaluate problematic situations is one which needs to be negated in order to accommodate criticisms such as the one outlined above. Principles reflect social values, and as long as such principles remain flexible and specifiable, then the model on which they are based need not be refuted.

One criticism which principlism may find it difficult to deal with in terms of substantive normative viewpoints relates to ten Have's list of characteristics particular to North American biomedical ethics. The fourth item on the list claims that "bioethics is general ethics applied to medicine" (ten Have, 1994:105). Ten Have explains that this fact mistakenly presumes that the contexts in which biomedical dilemmas arise are not unique. As an example of this position ten Have refers to Engelhardt's distinction between two levels of culture: 1) secularized pluralistic society and 2) multiple particular moral communities with competing visions of the good life (Engelhardt, 1986). Engelhardt posits that bioethics should occupy itself with the first of these two levels. To do this, Engelhardt emphasizes that biomedical ethics must speak the secular moral language of mutual respect. According to Engelhardt, speaking the language of mutual respect entails the repression of all other moral languages (ten Have, 1994:107).

Ten Have challenges this position, asking why we should abstain from our particular moral languages in favour of the "neutral common language." He answers his query by invoking the postmodern claim that a common neutral language is an impossibility. Even though there may be a common language, it is not impervious to the conditions of place and time, and consequently, is the product of "a specific moral community" (ten Have, 1994:107). What I believe is a stronger claim, and one which I will elucidate in later discussions regarding
care ethics, (Chapter VII), is that even if there were a neutral common language which transcended place and time, it would not necessarily be superior to, nor more appropriate or desirable, than a particular moral perspective. In any case, whatever the reasons are for endorsing a particular, contextual moral discourse, the fact remains that criticism of abstract, neutral language corroborates the argument that North American biomedical ethics lacks in substantive normative claims.

Assuming, for the time being, that particular moral positions have value independent of, or in harmony with, a neutral common language, it cannot be concluded that Beauchamp and Childress' version of principlism is unable to comply. It is true that Beauchamp and Childress do refer to their principles as "universal," a word which hints at ahistoricism and objectivism. What they understand by this term, however, is simply that universality requires consistency. In their words,

universalizability...demands consistency of commitment within a system of judgments, rules, and principles, but it leaves open for discussion exactly what will count as morally relevant similarities and differences and whether unanimity is reachable over principles and rules (Beauchamp & Childress, 1994:26).

According to this explanation, the universal aspect of ethical principles lies not in their ahistorical value, but rather, in the fact that "they provide a basis for the evaluation and criticism of actions in countries and communities whose customary viewpoints fail to acknowledge basic principles" (Beauchamp & Childress, 1994:100). Beauchamp and Childress corroborate this position by drawing a comparison between the universality of human rights and the universality of ethical principles (Beauchamp & Childress, 1994:100).

These statements exonerate Beauchamp and Childress from the criticism levelled by ten Have at Engelhardt with regard to the latter's assertion of a neutral common language. In fact, Beauchamp and Childress distinctly exempt themselves from this challenge altogether when they explain that the technique of balancing is particularly applicable to adjudication of individual dilemmas, whereas the method of specification is especially useful for policy development (Beauchamp & Childress, 1994:32). Specification, as I outlined earlier, is the process of dialectically establishing the substantive content of principles. In contrast, balancing is the act of determining the relative weight a given principle should have in comparison with
the others in a particular situation. If Beauchamp and Childress aligned themselves more closely with positions such as Engelhardt’s, it seems more likely that their two techniques would be reversed, specification applying to personal decisions, and balancing to policy formulation. If this were the case, there would be no room for the re-evaluation of ethical principles at the social level. The principles would be static, and in policy formation, the only way to alter past protocols would be to shift the balance from priority to one principle to priority to the other. The only flexibility in interpretation would be that which is available through balancing, which does not allow as much freedom as does specification. Specification, which allows the very principles themselves to be reinterpreted, and even abandoned and replaced if necessary, could only occur on a personal, subjective level. This would be problematic not only in light of the requirements of reflective equilibrium, but also from the vantage point of consistency. Allowing complete reinterpretation at the level of personal decision-making would invalidate policies in the first place. Although flexibility is allowed at the level of contextual analysis according to Beauchamp and Childress, it is not the kind of flexibility which admits of situationalism. Thus, rather than promoting the distinction between the public and the private spheres by encouraging different languages, Beauchamp and Childress associate specification with policy making, demonstrating that there is mobility and contextuality in the common language, rather than absolute neutrality, and that whatever language exists in the personal realm cannot be purely private. We will return to more of the distinction between private and public morality in Chapter VI.

Despite Beauchamp and Childress’ escape from ten Have’s contention on the basis of neutrality, it may appear that there remains a certain rigidity in their account of principlism. Because Beauchamp and Childress emphasize that specification is more suited to the establishment of principles at the first, or social level, to use Engelhardt’s terminology, it may seem to be the case that there is no room for adaptability at the level of the particular. In other words, if all that one ought to do at the level of individual decisions is to balance already specified principles against each other, it appears that contextual analysis is not a viable option. It is fair to say, however, that this is not the intention of the distinction which Beauchamp and Childress make between balancing and specification and the social and individual. As Childress clarifies, "Principles of Biomedical Ethics involves a dialectic between theory, principles, rules
and particular judgments (case judgments), with reflective equilibrium operating at each level, as well as between the levels" (Childress, 1994:75).

Beauchamp and Childress remark that "a confusing feature of contemporary moral theory is that false rivalries and misleading statements of method often result from pigeonholing theories too readily, and assuming that the proponents of one method exclude the other methods in their moral thinking" (Beauchamp & Childress, 1994:19). Although ten Have refers specifically to Beauchamp and Childress' version of principlism in his critique, it appears as if he conflates their perspective with those of other, more "absolutist interpreters" of principlism, such as Engelhardt (Childress, 1994:81). Ten Have's criticism could also be due to the fact that he bases his analyses on the third, (1989), rather than on the fourth, (1994), edition of Principles of Biomedical Ethics. Nonetheless, the changes made between the two versions of the book, although significant, are not substantial with regard to the issues on which ten Have focuses. I will now determine whether other critics have correctly identified Beauchamp and Childress' work as a target of anti-theorist criticism.

**A Buddhist Critique of the Principles of Biomedical Ethics**

In his assessment of principlism, Pinit Ratanakul acknowledges the need for principles, even in the presence of doctors who have not lost the trust of their patients. In Ratanakul's words, "even 'good' doctors, those who have morally good attitudes, dispositions, motives, and overall character, do not know intuitively how to decide complex moral questions" (Ratanakul, 1994:122). Rather than being a replacement, however, for virtuous character, principles are a step in the process of cultivating a virtuous personality (Ratanakul, 1994:123). (Parenthetically, we will see complete disagreement on this point in the work of James F. Drane.)

Ratanakul's critique of principlism focuses mostly on the principle of autonomy. He explains that in the ethics of Theravada Buddhism, there exists a deep respect for, and faith in, the individual and his or her uniqueness. This perspective allows Theravada Buddhism and principlism to coincide nicely with respect to principlism's endorsement of the principle of autonomy. Where the paths of Theravada Buddhism and principlism diverge is the point where principlism promotes autonomy at the expense of the individual's social context. There are two
ways in which this criticism can be interpreted.

The first interpretation focuses on the distinction between the good of the individual versus the good of the many. As Ratanakul elucidates, "by firmly embedding itself in this cultural value of individualism, principlism has oriented U.S. biomedical ethics to the well-being and welfare of the individual at the cost of the welfare of others, or the public good" (Ratanakul, 1994:125). With respect to health care, this mentality of individualism accounts for the fact that we speak of the "right to health care," which we understand as a private entitlement which individuals claim without respect for their social context or communal need. This prioritization of values leaves North American biomedical ethics in danger of reverting into egoism (Ratanakul, 1994:125).

Although Ratanakul refers explicitly to Beauchamp and Childress' form of principlism at one point in his paper (Ratanakul, 1994:123), it is not clear if he intends all his comments to be directed towards theirs, and other versions of principlism, with equal force. Considering the fact that Ratanakul never exempts Beauchamp and Childress' principlism from his criticism, it is worth anticipating their response to Ratanakul’s commentary as follows. In the fourth edition of Principles of Biomedical Ethics, (1994), Beauchamp and Childress criticize liberal individualists for writing as if the priority of social morality is "the protection of individual interests against government intrusion." They suggest that such a political view is too narrow, due to the fact that it excludes "not only bona fide communal demands and group interests, but also communal goods and forms of life" (Beauchamp & Childress, 1994:76). In addition to this very clear statement which directly shields Beauchamp and Childress from the criticism of "egoism," the very fact that they shun an a priori hierarchy among principles means that they do not necessarily promote individual rights over communal goods. Even in Engelhardt’s version of principlism, which asserts a hierarchical structure, justice is derivative from both autonomy and beneficence. In Veatch’s conception of principlism, he gives priority to non-consequential, or deontological, principles such as autonomy and justice over the principle of beneficence. In a case of conflict between autonomy and justice, he favours justice.

Nonetheless, Ratanakul’s criticism must be respected. Even if Beauchamp and Childress explicitly state their concerns about liberal individualists, it is nonetheless possible that in the process of specifying and, especially in this case, balancing principles, as they suggest in their
model, that autonomy, or individual interests, could consistently trump collective interests. It is certainly true that we often hear of sensationalized medical cases in which millions of health care dollars are spent in supposedly miraculous operations which attempt, for instance, to split siamese twins or save incredibly premature babies, in the name of the sanctity of individual, as opposed to collective, life.

The second way in which one can interpret Ratanakul's claim that North American biomedical ethics promotes the individual at the expense of the social is with regard to the individual himself or herself. Ratanakul writes of his concern that principlism "isolates the individual from the social context" (Ratanakul, 1994:124). His solution to this dilemma is not that principlism abandon its concept of autonomy in favour of a Marxist conception of the collective self or in favour of a paternalistic, authoritarian ideology. Rather, Theravada Buddhism suggests that the individual be perceived as being "in relation to others and the community as well as the whole social and cultural environment" (Ratanakul, 1994:126). In other words, it is not merely the fact that the collective good is sacrificed in the name of individualism which concerns Ratanakul, but it is also the fact that a tendency towards egoism can segregate individuals from something which is necessary to them: their connection and relationship to others. These are related, yet distinct points, the second of which will be paramount in our subsequent discussion on care ethics.

Translating Ratanakul's remarks into advice for the sort of principlism which Beauchamp and Childress recommend, it can be inferred that Theravada Buddhism counsels ethicists to be aware of the North American tendency to tip the scales of justice away from social fairness and towards individual rights. In the effort to balance principles, we must be critical of our sociocultural biases. From the second interpretation of Ratanakul's concern with the North American flirtation with egoism, philosophers are advised to be wary in the ongoing process of specification of how we specify such notions as autonomy. In later discussions, (Chapter V), I will give a more detailed analysis of how such concepts can be reorganized and reinterpreted, with respect to how they have been traditionally understood. Suffice it to say for now, that Beauchamp and Childress' principlism is not inherently unable to accommodate these recommendations.

Another important point which Ratanakul shares with his readers is the emphasis which...
Theravada Buddhism puts on compassion. Ratanakul explains that Buddhism and principlism do not conflict with regard to the use of the principles of beneficence, nonmaleficence and justice in dealing with dilemmas in biomedical ethics. What Buddhism maintains, however, is that these principles are all "superseded by compassion, which embraces and transcends them" (ten Have, 1994:126). By compassion, Ratanakul refers to something which is neither a sentiment nor an emotion, but rather, "radiates from the mind as a result of knowledge - the realization of the selflessness of all beings and the consequent, fundamental equality of all beings with one another" (Ratanakul, 1994:126). In light of health care, compassion entails not only an amount of self-sacrifice but also a feeling of gladness arising from helping those in need. With...recognition of the human condition [e.g., its vulnerability to pain and suffering] we can provide loving care to patients effortlessly and in a way that acknowledges them as whole persons with emotional, psychological, mental, and spiritual, as well as physical, dimensions (Ratanakul, 1994:126-127).

What is particularly intriguing about the idea of the primacy of compassion is the possibility that its status vis-a-vis principlism could offer a solution to the criticisms of those who are allied with Clouser and Gert, as well as those who share some of the criticisms of Baier and ten Have. Clouser, Gert and Green lament the absence of a more all-encompassing framework within which principlism could legitimately function. Baier and ten Have point to the thinness of North American principlism and ten Have suggests care ethics as an example of the kind of approach which could remedy the situation. Asserting the primacy of compassion over that of principles puts an umbrella concept over principlism, which would suit Clouser and Gert’s camp; and the importance of compassion would also fill the abstract form of principlism with a more substantive profundity, which would please thinkers such as Baier and ten Have. (In Chapter VI, we will look at Susan Mendus’ interesting contribution to the idea of the primacy of care/compassion in her suggestion that care is morally transformed into principles when extended from the intimate encounter to the impersonal world of policy formation.)

Of course, it is not apparent that Clouser, Gert and Green would accept a proposal such as Ratanakul’s in lieu of super-theory. Conceptually, however, the suggested primacy of compassion does provide, at least for Theravada Buddhists, an explanation and a justification for the principles which they promote. It allows for an understanding of why certain principles
are chosen and of how they relate to one another. Conversely, the primacy of compassion answers the question ten Have asks: What kind of society or community one is in, or wants to be a part of. This is a tentative suggestion, the reaction to which, especially from grand-theorists, I cannot represent. However, I will return to this idea again later, when we discuss the components of care theory. In addition, I will investigate how the arguments of some care theorists for the primacy of care relate to Ratanakul’s promotion of the primacy of compassion (Chapter VII). For now, I will turn to an exegesis of Richard M. Zaner’s treatise on phenomenology and biomedical ethics.

**Phenomenology and Biomedical Ethics**

In his article, "Experience and the Moral Life: A Phenomenological Approach to Bioethics," Richard M. Zaner implicitly supports Rothman’s historical analysis and assessment of relationships in health care. He claims that "invariably, the patient is surrounded by strangers (other patients and hospital personnel) and by strange equipment, schedules, and procedures. Sociologically and architecturally, hospitals and clinics seem to enhance more than to ameliorate this strangeness" (Zaner, 1994:226). Zaner refers to the enforcement of anonymous clothing, the absence of possessions, and unfamiliar surroundings to support his point. In situations where such conditions exist, coupled with the inability to rely on shared values, attitudes, desires or aims, "the ability to treat, heal, or restore is more difficult" (Zaner, 1994:227). Whereas Rothman reported that the discomfort and mistrust between doctors and patients was one of the catalysts for reliance on principles, Zaner uses the transformed relationship between doctor and patient as further proof of the necessity of a phenomenological, as opposed to a theory-centred approach to biomedical problem solving. As he elaborates, "clinical encounters evoke the need for responsive care from those in whom trust is invested" (Zaner, 1994:225). This responsive care entails more than what Eric Cassell refers to as "a narrow focus on disease and pain" (Cassell, 1991:30). To fully help the patient, to detect his or her sources of suffering, "requires candid discussion of a person’s sense of body and self, circle of intimates, social life, and goals" (Cassell, 1991:36). Thus a phenomenological approach requires that "experience is the point of departure and return for theory: its ground
and ultimate "test," what it must at once illuminate and elucidate" (Zaner, 1994:230). In other words, ethical dilemmas in biomedicine can only be deliberated on and resolved within the context of their actual manifestation. (We will see the above points elaborated on first in Chapter V, with regard to the need to broaden the definition of cure to include considerations of care, as Cassell hints at; and in Chapter VII we will revisit the discussion of context sensitivity, which Zaner emphasizes.)

The direction of deliberation between practice and theory, according to Zaner's approach, is initially from bottom to top, or from practice to theory. Although Childress emphatically points out that Beauchamp's and his principlism no longer necessitates a top-down approach, it is not evident that the identification of their principles originate empirically as opposed to purely conceptually. Beauchamp and Childress do inform us, however, that they include at least some *aposteriori* procedures in their approach: "our strategy accepts the goal of reflective equilibrium and, in part, constructs principles and rules from considered judgments" (Beauchamp & Childress, 1994:101). Whether this means that such principles as autonomy and beneficence are up for debate is unclear. However, it does imply that Beauchamp and Childress' principles are not immune to specification via experiential verification. Yet are they immune to *a priori* specification? Is the specification the principles an artificial endeavour which will never truly approximate the reality of biomedical dilemmas? In other words, the very questions which are asked in *Principles of Biomedical Ethics* may be misguided due to the static structural nature of principlism. The content of principlism may change, but can its form? Beauchamp and Childress acknowledge that after balancing and specifying in accordance with reflective equilibrium and coherentism, "we will not end up with the identical content with which we began" (Beauchamp & Childress, 1994:101). However, the issue of form, (e.g., the particular quartet of principles which Beauchamp and Childress promote) remains vague.

Whether or not a truly phenomenological approach would generate the principles Beauchamp and Childress choose is not a query I can answer based on Zaner's comments. A concept which Zaner does indicate would be generated from the phenomenology of clinical medicine, however, is that of relationship. As he states, "every situational constituent, including any moral issue, is presented solely within an ongoing relationship between patient and
physician" and "clinical ethics addresses that relationship itself" (Zaner, 1994:231). In fact, Zaner identifies the issue of relationship between the individuals involved in problematic situations as his primary interest (Zaner, 1994:217). There are similarities here to the discrepancy between Rothman and Fox (Chapter I) with regard to the absence of bioethics' "sociological imagination:" Fox blames a myopic focus on patient/physician relations, whereas Rothman believes that revisiting this relationship may help to bring larger sociological issues back into focus.

Linked with the concept of relationship are themes which Robert C. Hardy has identified in encounters with illness. The first of these is the need of patients to know what is wrong with them. The second of these is the need of patients to feel that the people who are taking care of them really care (Hardy, 1978). In George Engel’s words, there is a "need to know and understand and the need to feel known and understood" (Engel, 1988:124). The first of these themes can be construed as falling under the category of autonomy insofar as the principle of autonomy generally includes the right to information about one’s own case. The second of these themes, however, is more difficult to classify. Are the needs for relationship and the desire to be understood covered by the principle of beneficence? Are they part of promoting patient good? I argue that these issues can indeed be included in the concept of beneficence, but that, at least abstractly, they usually are not. The term "beneficence" is normally included in the discourse of physical health and technical cure. The concepts of care and relationship, on the other hand, are not generally included in its substantive content. Consequently, to inform beneficence of these paramount aspects of clinical encounters requires a significant effort in restructuring and informing biomedical ethics from the bottom up. Such a phenomenological enquiry informs our understanding of principles. It is exactly such an approach to bioethical principles which many critics of principlism are hoping for and working towards. (See the care versus cure debate in Chapter V.)

**Virtue Theory and Biomedical Ethics**

In his article, "Character and the Moral Life," James F. Drane implicitly supports Zaner’s position on many counts. With regard to the evolution of principles, Drane agrees that
experience, rather than abstract theory, is the primordial soup. He tells a story of a friend of his who helps a drunken man get home by putting him in a taxi after locating his address in his wallet. In reflecting on this account, my first reaction, which I presume to be shared by many principlists, is that the benevolent friend in this case performed a supererogatory act. If one's belief of what is included in the principle of beneficence is quite extensive, one might argue that the friend performed his requisite beneficent duties. Drane argues, however, that although we could interpret his friend's actions through a principlist lens, such a translation of the course of events would be insufficient. There are things which principlism cannot, or perhaps might not, be able to account for. Thus even if specification and balancing can allow flexibility and the possibility of more inclusiveness, it still might be the case that they are minimalist, being able to address only certain aspects of moral life. As Drane puts it, "no ethical rule either abstract or concrete could be found that would require a person to take the subtle and delicate steps...to achieve that final excellent result. Doing the excellent thing [is] a matter of intuiting what [is] appropriate" (Drane, 1994:287).

There is truth to what Drane says. However, I would like to point out initially that Drane takes a rather extreme position, which is opposite, but similar in style, to that of the grand-theorists. Although it may be true that it is necessary for theoretical principles to be informed by experience, it is not the case that all "intuitive" acts transcend concepts of acceptable behaviour. Drane's friend's behaviour did not arise out of pure intuition, so to speak. This intuition was informed by ideas of what was right. And such ideas do not arise spontaneously out of an intuitive big bang, but rather, are learned from societal ideologies of right and wrong. At first glance, it might be thought that my criticism of Drane contradicts what was said earlier with regard to Zaner's comments on the importance of experience. What Zaner points out, however, is that experience must inform decisions, and that the knowledge afforded by principles is not adequate to properly deal with the intricacies of a particular context. What Drane's remarks imply is that intuition is the only impetus for truly morally adequate behaviour. This conclusion could be seen in terms of intentionality, insofar as moral behaviour cannot exist in the absence of morally appropriate intent, a position against which I am not arguing here (see Nagel on Kant, 1990:174). Intuition in isolation, however, has been, and can be, the source of very immoral actions, just as theory in isolation can be the source
of distorted prescriptions. If Drane’s position is that intuition is sufficient, as opposed to merely necessary, to morally good behaviour, then his argument structurally reflects that of the grand-theorists who wish to pronounce theoretical concepts as sufficient information for ethical conduct.

It may be that Drane’s argument is that virtuous intuition is merely necessary for truly moral action. If this is the case, Drane’s contentions may be related to an association which Ratanakul draws between Theravada Buddhism and Beauchamp and Childress’ principlism. Ratanakul writes that Buddhists agree with Beauchamp and Childress in that "specifically, for medical practice, the important virtues are correlated with the duties and ideals of the profession. Virtues are settled habits and dispositions to do what we ought to do" to fulfil our professional obligations" (Ratanakul, 1994:123). In this sense, virtues are seen as related to and connected with principles. It is interesting to note that in Ratanakul’s discussion, he identified the virtue he believes to be primary, namely, compassion. This is very different from Drane’s blanket reference to generic virtue. Compassion is primary, in Ratanakul’s account, because of its specific relationship to the principles and ideals of the medical profession. He even claims that compassion is one of the motivating reasons which explain why certain people choose to enter the field of health care. Although I contest this position, due, for the most part, to the fact that financial incentives may have, in some cases, superseded the motivation of compassion at least in North America, Ratanakul’s comments elucidate a particular connection between a specific virtue and principles connected with it.

What we can draw from Drane’s article, despite a disagreement on his rather absolute endorsement of intuition, is that despite how much we try to specify principles, they are not adequate as action guides because they are insensitive to emotive or intuitive components, which are essential, in Drane’s view, to the foundation of true moral behaviour. As he claims, "external acts and behaviours can be made subject to law, but not inner being or character" (Drane, 1994:289). The fact that our predominantly principlist system has gradually endorsed rules and regulations, as opposed to trying to promote the more invisible internal values and virtues, is, according to Rothman, due to the fact that reliance on emotive and intuitive inspirations failed in comparison with the stronger desires for research success and utilitarian ideology. With this in mind, it is no wonder that reliance was placed on external enforceables
rather than on internal intangibles. What Drane makes apparent, is that this reliance became excessive. Instead of actively trying to rejuvenate the virtuous dispositions which had been degraded or abandoned, this project was rejected in favour of, perhaps the superficially more simple one of drafting legislation, be it legal or moral.

Like Zaner, Drane encourages more focus on the relationship between doctors and patients. He claims that "the character and virtues of a good doctor derive from the needs of patients" (Drane, 1994:297). He later continues on this vein, suggesting that "character and virtues are important today because they have everything to do with the quality of a doctor-patient relationship. Nothing is more important to a patient than this relationship, yet attention to it has dropped out of both mainstream medicine and medical ethics" (Drane, 1994:305). This quote ties in directly with what Zaner discussed above in his reference to the need for patients to understand and to be understood, and furthermore, to the need to know that their caretakers actually care.

It is true that ethical principles cannot replace internal and intangible qualities. However, I disagree with the idea that principles are not related to the endeavour "of refocusing attention in mainstream biomedical ethics on character and virtue" (Drane, 1994:307). The two needs which Zaner identifies in doctor-patient encounters can be promoted by the specification of the principles of autonomy and beneficence. Autonomy can, and currently does, include the requirement of providing patients with information about their situation. And beneficence can be defined to include the incitement to try to understand where patients are coming from and to truly feel and manifest care for them.

**Conclusion**

The perspectives which I have described and critiqued in this chapter serve as a backdrop against which to examine the comments and criticisms of the proponents of care theory. We have looked at Henk ten Have's European challenge, in which he criticizes the supposed "applied" approach of principlism, its apparent focus on clear-cut solutions, its lack of historical perspective and sociocultural awareness, and its unphilosophical foundation. Pinit Ratanakul discusses the North American focus on liberal individualism and its inattention to
compassion. Richard M. Zaner argues for the need to revisit the phenomenological aspects of the physician-patient encounter and to inform principism with experiential facts. James F. Drane reminds us that virtue and inner intangibles are paramount to the practice of biomedical morality, and again, that relationships are primary.

What now needs to be determined is, firstly, what the evolution of care theory is, and what its supporters maintain. The preceding commentaries will enable us to decide if the contentions of care theorists differ substantially from the criticisms of the authors cited above, and if so, to what extent and in what manner. In the following chapter, I will make some necessary clarifications with regard to the literature surrounding care ethics. I will distinguish my examination of this ethics both from a feminist account, and from a nursing account. I will also address a confusion in the literature between "care ethics" and "care" itself, or "caring behaviour." In the last three chapters of this work, I will address the relationship between care ethics and Beauchamp and Childress' principism, and will demonstrate possible ways in which the principles can be specified in light of the contentions of care ethicists. I will also look at the issues of context and relationship, and will investigate their relevance to the whole of biomedical ethics. We will see that many of the areas of concern of care ethicists reflect those touched on in this chapter. Thus care ethics is not a fully new field with unique queries. Rather, it is an amalgamation of many different voices of concern, including those referred to here. Care ethics is an extension of the anti-theory trend away from grand-theory, away from traditional definitions of what is legitimately of interest to morality, away from techniques of abstraction and theoretical authoritarianism.
CHAPTER IV
The Evolution of Care Ethics

Introduction

In the following chapter, I will review the recent evolution of what has become known as "the ethics of care" or "care ethics." First I will provide a synopsis of the disagreement which occurred between psychologists Lawrence Kohlberg and Carol Gilligan in the late nineteen-seventies and the early nineteen-eighties. My exegesis of their discord will offer an empirical explanation for the initiation of interest in what Gilligan called "a different voice," which she contends is the essence of care ethics. Gilligan's work addresses the ontological assumptions of human moral development, and the moral epistemological conclusions to which they lead.

Secondly, I will give a socio-political analysis of why care ethics has become what Alison Jaggar refers to as "a little industry." For feminists, and particularly for the nursing profession, care ethics has become the focus of increasing study. Because the results of Gilligan's experiments indicate that the care perspective is largely manifested by women, female scholars have investigated the exclusion of this moral point of view from the mainstream, and have asked if care ethics is a viable moral perspective to hold in the public, as opposed to merely the domestic, realm. For the nursing profession, it is claimed that care ethics has particular relevance due to the fact that the history of nursing proves it to be a vocation which embodies caring activities and attitudes. In the interests of promoting their profession, as well as the ideals which it represents, nursing theorists wish to establish the validity of their practices as more than simply derivative from and subordinate to the principles and ideology of modern medicine.

Thirdly, I will direct our attention to the evolution of the term "care ethics." I will claim that the title, "the ethics of care," has become co-opted and misrepresented by those theorists who conflate two very different uses of the term "care." On the one hand, "care" is a term which is contrasted with the term "justice." On the other hand, "care" is associated with emotive involvement and feelings for others. I will argue that an interpretation of the "ethics of care" which conflates these two definitions of the term "care" is faulty, and in some cases even
dangerous to the enterprise of feminism as well as to the scholarly endeavour to expose shortcomings in our dominant ethical perspectives.

**The Kohlberg/Gilligan Disparity**

In the 1950s, Lawrence Kohlberg conducted studies on eighty-four males from childhood to adulthood, over a period of twenty years. His intent was to establish the pattern of moral development. His conclusions claimed that there are six stages of moral maturation which are universal (Gilligan, 1982:18). These stages follow a three-step progression from "an egocentric understanding of fairness based on individual need" (stages one and two), to "a conception of fairness anchored in the shared conventions of societal agreement" (stages three and four), and finally to a "principled understanding of fairness that rests on the free-standing logic of equality and reciprocity" (stages five and six) (Gilligan, 1982: 27). What is significant for the purposes of our discussion is that in stage four, relationships are subordinated to rules, and that in stages five and six, rules are inferior to universal principles of justice (Gilligan, 1982:18). This hierarchical structure parallels the kind of theoretical construction encouraged by Clouser, Gert and Green, and thus clearly falls into the classical theory camp.

What became apparent to Gilligan in her interviews with, and studies of, girls and women, was that they consistently scored lower on Kohlberg's scale than did boys and men. This was not merely because females could not analyze in the same manner as could males. This result was due to the fact that the very means by which females reasoned morally were seen as mutually exclusive of the techniques employed by, or at least promoted in, males. Gilligan describes this state of affairs as a "paradox." She claims that "the very traits that traditionally have defined the "goodness" of women, their care for and sensitivity to the needs of others, are those that mark them as "deficient" in moral development (Gilligan, 1982: 18).

The essence of what Gilligan observed was that the women she studied had a different ontological conception of themselves and others, indeed, of the relationship between the self and the other, and that consequently, they had an alternative moral epistemology to that of the men Gilligan and Kohlberg studied. Since Kohlberg's analyses were conducted exclusively on men, it is not surprising that they did not reflect the moral methods of women. What Gilligan's re-
analyses proved, is that there is not only one single possible ontology and corresponding epistemology.

What is not so clearly proven, and I will argue need not be, is whether the two different voices which Gilligan identified are necessarily gender specific. Gilligan cites the work of Nancy Chodorow, which establishes that the fact that girls and boys are socialized differently is reflected in the type of sense of self and others that they develop. Because girls do not feel the need to separate from their primary care-giver, they develop an ontology of connection to others; their sense of autonomy includes interdependence, not separation from others. Young boys, on the other hand, being primarily nurtured by their mothers (at least in North American culture), feel the need to separate as they mature. They need to define themselves as different from their mothers, as separate and autonomous. In essence, Chodorow attributes the different voices of the sexes to the fact that women are responsible for early care-giving (Gilligan, 1982:7).

Robin West reviews a similar but distinct account for the different conceptions of autonomy and relationship which men and women develop. The account West presents, unlike that of Chodorow, borders on essentialism rather than on socialization. West discusses the position of some radical feminists who claim that because women have the potential to be pregnant, and because being pregnant entails a fundamental connection between the self of the woman and the fetus, women tend to think in terms of relationship to others rather than in terms of separation from them. Furthermore, because the relationship between a woman and her fetus or young child is one of inequality rather than equality, the feminine account of social relations is more caring than one based on the conception of equality and separation which posits rights and contracts (West, 1988:580). Consequently, the potential for pregnancy establishes an essential, rather than socio-culturally derived ontological position of women from which an epistemology of connection and caring follows.

There are stronger essentialist accounts which posit that women actually think and know things differently than men do simply by virtue of the fact that they are women. This position claims that women have an innately distinct epistemological ability. I reject this position as not only untrue, but as dangerous due to the fact that it perpetrates the ideology that women, as well as men, are confined by their biology. Susan Mendus illustrates this point as follows:
In urging a move from abstraction to contextualization and from considerations of justice to considerations of care, feminist theorists tread on sensitive ground. From Aristotle to Hegel, woman’s special nature of ‘different’ voice has been used as the primary justification for her confinement to the domestic realm and her exclusion from political life. Thus, notoriously, Hegel tells us that ‘When women hold the helm of government, the state is at once in jeopardy, because women regulate their actions not by the demands of universality but by arbitrary inclinations and opinions’. Similarly, Rousseau declared that ‘a perfect man and a perfect woman should no more be alike in mind than in face,’ and western political philosophy is replete with similar examples of arguments which move from the assertion of woman’s different, caring nature to the conclusion that she is unfitted for public life. Against this background, the aspiration to employ an ethic of care in pursuit of feminist ends must be treated with considerable caution (Mendus, 1993:18).

The consequence of supporting a different voice is that some feminists who endorse it are trying to promote the caring perspective on the basis that what women are and do should be valued equally to what men are and do, even in the public realm. Ester C. Condon makes this point when she explains that

the image of the visible carer developed from the argument that, despite the disvaluing of women’s caring caused by the dominance of the male value system, caring should not be changed and women need not stop caring. Rather the worthiness of caring as an activity should be recognized (Condon: 16).

Although I think that in some cases such re-evaluation is imperative, for instance in cases analogous to the 1960s "Black is Beautiful" movement, to promote the care perspective on the basis of the promotion of women may not only be disadvantageous to some women, as Mendus illuminates, but may also be detrimental to the study and promotion of care ethics. Of course the first statements Condon documents need to be realized. Caring must be seen as something of value, but not simply in order to promote the position of women in society. In other words, the distinction between care ethics as part of a feminist agenda and as part of an evaluation of the ontology of relationship, moral epistemology and normative injunctions must be recognized. Laura Purdy’s statement corroborates my view: "[W]hat we don’t want is a special interest ethics which can be ignored, or relegated to the already large collection of theories among which people can arbitrarily pick and choose." What Purdy hopes is that in the long term, "feminism will permeate all ethics, leaving ‘feminist ethics’ to wither away" (Purdy: 11).
Care Ethics and Nursing: Professionalism Vs. Philosophy

It is particularly with reference to the nursing profession that this distinction must be made clear for the purposes of this thesis. Whereas I wish to examine the ethics of care on the basis of its moral merit, there are some nursing theorists who intend to promote care ethics on the basis of a claim which reflects the essentialist arguments outlined above. These theorists suggest that "an ethics of care and caring has been described variously as a moral ideal of nursing and as a fundamental value of the nursing profession" [Watson, 1985; Condon, 1988; Fry, 1989] (Condon, 1992:16).

A stronger claim is made by Madeleine Leininger in her statement that as nursing becomes more recognized and established as a discipline, "it will be essential for nurses to know the nature, scope, and distinguishing features that characterize nursing from other health disciplines." Leininger contends that "caring behaviour and practices uniquely distinguish nursing from the contributions of other disciplines" (Leininger, 1988:4).

Jean Watson concurs in her claim that "nursing ethics should be distinguished by its philosophy and moral ideals that affirm the personal unique contextual experiences associated with human caring, inherent in nursing qua nursing" (Watson, 1988:2). Watson points out that until recently, nursing ethics was considered a subset of medical ethics. Some authors, she continues, are now realizing that "nursing ethics is a legitimate term and focus of study that refers to the ethical issues and analyses used by nurses to make ethical judgments." What makes this claim pertinent for my purposes is that Watson associates nursing ethics with care ethics: "the field of nursing ethics, [is] now commonly referred to as the Ethics of Caring" (Watson, 1988:1). Sara Fry stands by Watson in asserting ownership over the moral ideal of caring which is "unique to nursing" and therefore, distinguishes nursing ethics from medical ethics (Peter & Gallop, 1994:47).

The above statements hint at a desire for professional distinction rather than at a sincere interest in an alternative approach to ethics. These claims are very different from others which suggest that "theories of medical ethics as currently proposed do not seem appropriate to the development of a theory of nursing ethics" (Fry, 1994:103), and that "the metaphor of caring has
evolved as a significant one for nursing, one different from the previous metaphors such as religious calling, duty in the battle against disease [etc.]" (Condon, 1992:19).

I am not arguing that to support care ethics for professional recognition is inherently wrong, but rather, that a case for care ethics must be made on its own merits. Anders Lindseth, however, makes a stronger claim when he says that "it becomes alarming if we want to develop an ethics of caring...or a separate nurse ethics in opposition to physician ethics" (Lindseth, 1992:98). Yet it need not be the case that examining care ethics even through the lens of a feminist agenda results in the segregation of women's methods of moral reasoning and action from those of men (assuming the existence of a still distinct gender segregation between nurses and doctors). Indeed, as Virginia Warren explains, the result of examining the sexism of occupational roles could be synthetic rather than antagonistic: "We need to stop segregating nurturing from theory,...in health care ([e.g.] the work of nurses and social workers from that of physicians)" (Warren, 1994:36).

In any case, even if the intent of some writers is to promote care ethics because of its association with women or with a dominantly female profession, I submit that it should still be determined in advance whether or not care ethics is a viable alternative or addition to the dominant biomedical model of principlist ethics. It may be valuable to encourage and re-evaluate different modes of being, thought or action simply because they are integral to certain people or groups. However, before care ethics should be adopted in the realm of health care ethics, it should be determined to be an appropriate moral approach in this field.

In their paper on feminism and health care Jevne and Oberle make this clear: "We challenge the reader to put aside preconceived ideas about what feminism entails and to consider what this philosophy has to offer, aside from its perceived political implications" (Jevne & Oberle, 1993:2). Their understanding of feminism is that it is not about differences between male and female....Feminism is, above all else, about wanting and working for change...toward a better society....It is about accepting new ways of advancing our understanding of the complexities of the human body and mind (Jevne & Oberle, 1993:2).

As Annette Baier, albeit somewhat tenuously, puts it, women are not the only ones who have expressed discontent with standard approaches in moral philosophy. She bestows "the status
of honorory women" on such writers as Michael Stocher, Alasdair MacIntyre and Ian Hacking for their work, assuming, as she does, that "for whatever reason women seem to attain [some moral insights] more easily or more readily than men" (Baier, 1993:20).

The point Jevne and Oberle make above confirms the question which Henk ten Have posed earlier in Chapter III. Ten Have asks if the principles and conceptions of morality we support are those which promote "the kind of society we want" (ten Have, 1994:114). Translating this point into the language of health care, Jevne and Oberle recommend that "[i]t is time for a reassessment of the values that drive medical research. It is time not only to accept alternatives to the prevailing paradigm, but actively to seek them" (Jevne & Oberle, 1993:5). What Gilligan's observations establish is that there is a very different vision of social relations which we may want to endorse. The verification of an alternative ontology and epistemology implies that the choices we have with regard to society are not only choices amongst competing principles, but rather, among different ontologies and different epistemologies.

Following the line of argument that suggests we look at the substantive claims of care ethics, rather than at the feminist agenda associated with this ethical perspective, we will now turn to an examination of the tenets of care ethics and their potential contribution to moral philosophy.

**The Evolution of Terms: "Care" as an Ethic Vs. "Care" as a Feeling**

What exactly are the claims of proponents of care ethics? On what beliefs is such an ethic founded, and what are its prescriptions? In what follows I will provide various versions of care ethics. What will become apparent is that there is not necessarily one, universal definition of care ethics and its stipulations. In fact, some elaborations of what care ethics entails are fundamentally different from one another. I will argue that only some of these are tenable in the health care arena, yet that their tenability does not entail the rejection of principlism as Beauchamp and Childress define it. The ways in which care ethics differs from some of the anti-theorist positions discussed in Chapter III will also be established.

Returning to Gilligan's work, a number of assessments of her results have been made. In Susan Sherwin's words, Gilligan recognized two different patterns of reasoning: "one which
pursues universal rules in an endeavour to ensure fairness, and one which is focused on the actual feelings and interactions of those involved" (Sherwin, 1994:18). Sherwin's analysis goes further to identify two categories of difference between the largely male, or, as it is termed, "justice," perspective, and the more dominantly female or "care" perspective. On the one hand, care and justice ethics value different things, and on the other hand, they exemplify "methodological differences" (Sherwin, 1994:19).

In the category of things to be valued are attention to relationships (Purdy, 1994:11), mutual self-actualization (Ray, 1988:27), comfort, support, compassion, empathy, touching, nurturance, protection (Gendron, 1988:3), the effect of moral choices on others and the alleviation of suffering (Peter & Gallop, 1994:48). With respect to methodology, care ethics demonstrates reasoning which is based on "a very strong sense of being responsible to the world" (Gilligan, 1982:21), which includes contextual deliberations, non-hierarchical reasoning, personal, rather than impersonal, interaction (Gatens-Robinson & Tarvydas, 1992:26) and may entail the primacy of situation over principle (Peter & Gallop, 1994:48).

Looking more closely at the famous case which Gilligan analyzed in refuting Kohlberg, we may get a better sense of how these aspects of care ethics are manifested. The case involves two eleven year old children named Jake and Amy. They are asked to give moral responses to a scenario involving a young man called Heinz whose wife is desperately ill. The pharmacist has the drug Heinz's wife needs but at a price Heinz cannot afford. What should Heinz do? Jake's response polarizes the case: 1) let the wife die, or 2) steal the drug. Because of the way he has learned to prioritize the principles of life and property, he values life over possessions, and suggests that Heinz steal the drug. Amy's response does not dissect the case into the dichotomous and mutually exclusive choices that Jake identifies. Rather, she considers the long-term relationships involved in the case. She wonders if the wife would feel remorseful at the idea of her husband committing a crime in order to procure the drug for her. She wonders if the husband couldn't get the drug in another fashion, for instance, by communicating with the pharmacist and explaining the dire nature of the situation to him.

From this, and other experiments, Gilligan began to define the characteristics of what she called care, rather than justice, ethics. I suggest that the term "care" in Gilligan's work is chosen insofar as the care approach seems more caring, because it is concerned with more intimate and
personal issues, and because it demonstrates this interest in a very particularistic, context-sensitive manner. I do not believe, as subsequent proponents of care ethics do, that the term "care" was chosen to prove that agents of care ethics care more about others than do agents of justice ethics. What has transpired as the phrase "care ethics" has been industrialized, to use Jaggar's terminology, is that some authors have claimed that it is synonymous with the behaviour that follows from truly caring for and caring about others.

In the Heinz case, however, a heightened concern for either life or property is not necessarily evident in Amy's response. Rather, it is the other aspects of life which she identifies and Jake ignores, which make Amy's response unique. It is what she sees as valuable to life, i.e., relationships and communication, and the methodology with which she identifies what she values, i.e., non-hierarchical and non-antagonistic reasoning, which differentiate her perspective from Jake's. Whereas I link Amy's response to an alternative ontology of the self, as I discussed earlier with regard to Chodorow's and West's remarks, other writers associate Amy's remarks with an affective requirement.

The connection between care ethics and the affective component of caring, which I dispute, is championed in the work of Nel Noddings. As Eileen Margaret Sowerby recounts, "relation, for Noddings, is 'ontologically basic' [Noddings, 1984:3]. This simply means that a person acknowledges 'human encounter and affective response as a basic fact of human existence" (Sowerby, 1994:7). According to Sowerby, there is a necessary enchainment between an ontology of connectedness, affective response and an ethics of caring. As she puts it, "I do not think that it can be done: one cannot get to an ethics of caring, symbolized by the truly caring and interdependent person, starting from a rational, self-interested, and independent person" (Sowerby, 1994:74). There is an important difference, however, which I suggest Sowerby misses, between caring about certain things and manifesting an affective caring sentiment in every action which promotes those things about which one cares.

Furthermore, there is nothing inherent in the justice perspective which entails the absence of the affective aspect of care. An ethic of justice can be equally derived from care for others. What is at issue is what one cares about; as ten Have puts it, What kind of values do we want our moral perspectives to support? Justice ethics supports values of autonomy and impartiality. I do not believe it can be argued that these are values which only non-caring people or indifferent
societies can encourage. It may be that their promotion results in what appears to be dispassionate, non-caring behaviour towards certain individuals in specific circumstances. Yet to avoid such results categorically would be to endorse an impractical subjectivist ethic in which each person is always treated according to his or her own conception of caring - an ethical egoism of sorts.

In her discussion of the ethics of care in nursing, Anne P. Griffin parallels Noddings' sense of care. She claims that caring is part of the concept of personhood without which a person could be considered crippled. Caring for Griffin denotes a primary mode of being in the world (Griffin, 1983:289). The ethics of care in the context of nursing, she continues, necessitates a constant state of "emotional" interaction with, and the absence of egoism towards, the patient. I disagree with this assessment and contend that the mandate to perform every duty with emotional interest in the patient renders the nurse vulnerable to situations in which such emotional involvement is not warranted, and even undesirable. A patient may be abusive, for instance, or too demanding; a patient's physical and emotional state may be too traumatic and depressing to get emotionally involved in.

In Marilyn Ray's analysis of "caring" within nursing, she reviews excerpts from interviews with women regarding what it means to care. Among them are the following remarks: "Care is going beyond what is required. It is giving and not wanting anything in return. It is just love." "Care is the willingness to give of time, energy, love, prayer, or whatever is needed at what time it is needed - even when one doesn't feel like giving, or when the time is inconvenient." "Caring means the willingness to put another person and his/her needs before one's own." "Care is when your concern for another comes before your concern for yourself." Ray concludes from these contemporary sources, that "it is evident that caring is perceived as involving a process of co-presence, giving, receiving, communication, and in essence loving in the sense that Marcel conveyed; that is, ablative love or other-directedness" (Ray, 1988:31).

In other words, Ray perceives no inappropriateness or even danger in these definitions of care. However, as Jaggar warns, "within a hierarchical society, the norms and values that predominate tend to serve the interest of the dominant groups....Consequently, we are all likely to develop an emotional constitution that is quite inappropriate for feminism" (Jaggar, 1989:143). In Susan Reverby's historical analysis of the nursing profession, she explains that in the 1800s,
nursing was part of a young woman's apprenticeship into mature womanhood. It was a woman's obligation, not her job: caring was an unpaid labour of love (Reverby, 1987:5). It is quite clear at this point how the fact that women's experience should be valued *qua* women's experience does not entail the requirement to adopt or promote that experience, especially if, as I posit the above citations suggest, the experience of women is oppressive and dangerous. As Daniel Putnam reiterates, "[I]ike other virtues such as honesty and loyalty, caring opens the agent up to possible exploitation" (Putnam, 1991:236).

Sowerby points out that Noddings does not take this possibility into account. Sowerby relates the fear that women,

as the main care-givers in our society, are often insufficiently autonomous and unable to stand back far enough to breathe in a little liberating objectivity. Lack of female autonomy, leading to self-sacrifice, (see Bonnie Strickling, 1988), seems to be due largely to socially imposed gender differences affecting how one is raised (Sowerby, 1994:53).

This observation is notable in light of Noddings' conception of moral epistemology. In Sowerby's words, Noddings claims that "if there is no grounding in the caring attitude, other positions "beyond morality" could be used to justify horrendous activity [Noddings, 1984:43, 85]" (Sowerby, 1994:27). Clearly, as we have just seen from the previous demonstrations of the connection between care and the exploitation of care-givers, grounding morality in a caring attitude does not necessarily prevent all evil, especially if an affective component is encouraged as a requirement of an ethic of care.

Sowerby suggests that "caring is usually considered, in philosophical circles, to be a feeling, and, as such, to be subjective, relative, often capricious, and difficult to discuss rationally and objectively" (Sowerby: 1994:15). Patricia Benner echoes this sentiment: "It has been questioned whether caring as an art is amenable to scholarly inquiry" (Benner, 1984). I challenge these statements not because I do not think that it is a worthy philosophical enterprise to investigate the relationship between emotions and reason, but because I maintain that it is not the emotive aspect of caring that is essential to this discussion of care ethics. Caring intention and caring behaviour are not synonymous with care ethics. Recall here Ratanakul's differentiation between compassion and feeling (Chapter III). In support of this distinction, Robin S. Dillon
differentiates care from "liking or loving, and from fearing...all of which have their source in the agent's own desires and interests" (Dillon, 1992:108).

It is true that there is a bias against emotional involvement which must be addressed. As Jevne and Oberle point out with regard to professionals such as doctors, there is a "long-standing assumption that a professional is "objective" - a perspective supported by traditional views of science. Unfortunately, to many practitioners, this seems to imply that they must suppress feelings related to caring" (Jevne & Oberle, 1993:5). I do not wish to argue that natural feelings of caring must be suppressed - on the contrary. However, I do not think that, according to care ethics, immediate emotional involvement is essential to an ethical act.

My statement must not be confused with an endorsement of the assertion that, as Jaggar explains, "within the western philosophical tradition, emotions usually have been considered as potentially or actually subversive of knowledge.... Reason rather than emotion has been regarded as the indispensable faculty for acquiring knowledge" (Jaggar, 1989:129). My point is that accepting caring dispositions and caring behaviour as an epistemological source is different than requiring the presence of such affective and active components of caring in every act included in the sphere of care ethics.

Supporting emotional "caring" involvement approximates the virtue ethics perspective which maintains that a caring disposition is one which contributes to the creation of an ethical person. Daniel Putnam suggests that caring is virtuous; it increases the individual's potential; it increases one's repertoire for ethical acts; it liberates the agent to participate fully in practice (Sowerby, 1994:42). I argue that these advantages which the virtue of caring can allow, do not require "caring about" specific others. To amply carry out the actions which care ethics would support, it is necessary to "care for" the individual(s) involved, but this does not entail "caring about." In the example which Drane gives in Chapter III of his friend who put a drunken man in a taxi cab, Drane explains and justifies his friend's behaviour as principle-free conduct. It does not follow, however, that the professor actually cared about the drunken man, but rather, that he cared for him in this situation.

This distinction is paramount, for it is exactly this emotional or affective interpretation of care ethics which can keep it in the private sphere and render it inadequate for larger social ethics. Lindseth Anders clarifies my point by making a distinction between focusing on
relationships in an ethical theory, and focusing on the feelings between the participants in this relationship:

If we are to justify our caring actions, we must look more closely at the caring relation and clarify what makes this relation ethical or unethical. We need a relation ethics which clarifies how we meet the challenges and relations in life in a good way. A relation ethics of this kind cannot be based on feelings (Lindseth, 1992:102).

In other words, Lindseth recognizes that focusing on relationships and emotions as morally legitimate does not entail guiding moral action by emotional involvement. Although this is not the same claim as the suggestion that emotional involvement is a necessary criterion of care ethics, it is equivalent to Griffin's position insofar as Griffin heralds care as the primary ideal of nursing - its first principle. Due to the fact that Griffin associates care with affective components of caring emotions, it follows that her version of care ethics does approximate the kind of ethical framework Lindseth warns against.

**Conclusion**

In this chapter, I have examined key features of care ethics. I distinguish between promoting care ethics because of its (questionable) feminist implications, or because of its professional consequences for the nursing profession on the one hand, and because of its philosophical implications, on the other. Furthermore, I have made a clear distinction among differing and incompatible uses of the term "care ethics." Although the term is used to refer to an ethical perspective as well as to the behaviour associated with that perspective, this confusion is one that can be remedied by clarification. On the other hand, the claim that care ethics necessarily entails caring about, as opposed to merely caring for, other people and their situations, is one that is incompatible with my vision of care ethics.

In the next chapters, we will see how this distinction serves to help care ethics, as I interpret it, to respond to some of the challenges posed by dominant versions of ethics, including principlism. We will look at how care relates to the principles of autonomy and beneficence, and will determine whether the prescriptions of care derive from other established perspectives, such
as those examined in Chapter III, or whether espousing care ethics necessarily entails a divorce from other ethical theories, including the theory of principlism.
CHAPTER V

Care Ethics and Principlism: Constitutive or Derivative

Introduction

In the previous chapter, I reviewed the development and evolution of what is known as care ethics. I explained how the terms were borrowed from Gilligan in the service of some branches of feminism and in the professional interests of nurses. Although it may be argued that the adoption of Gilligan's terminology is fruitful for these two enterprises, my interests lie in the implications of care ethics for ethical theory, particularly in the arena of health care.

As I argued earlier, I maintain that the co-option of Gilligan's label, "care ethics," is misguided in some cases. The term "care" is not synonymous with caring emotions and feelings, but rather, it is synonymous with what the agent sees of value, and how she adjudicates among the things he or she values.

What now needs to be examined is what care ethics encourages us to care about. Does the care perspective value different things than, for instance, the principles of biomedical ethics do? Are the things care ethics values constitutive of, compatible with or derived from, the values promoted by principles of autonomy, beneficence, non-maleficence and justice? If care ethics supports things which principlism does not, do other theoretical perspectives such as phenomenology, virtue ethics or hermeneutics already identify and account for principlism's shortcomings? Or does care ethics offer unique insights into moral theory?

My specific focus in this chapter is how the tenets of care ethics as I identify them can inform the specification of the principles of Beauchamp and Childress' principlism. I will look particularly at how care ethics would reformulate the principles of autonomy and beneficence.

Care Ethics and Principles

Assuming for the moment that the principles endorsed by principlism represent, at least formally, goods which care ethics also espouses, I will examine the way in which the tenets
of care ethics would revise the principles of autonomy and beneficence. This examination will help us to determine how care ethics relates structurally to principlism in terms of being constitutive, compatible or derivative. Although it is plausible that care ethics will necessitate the creation of other principles in order to accommodate its premises, I will look initially at how the general concepts and values which the principles of biomedical ethics uphold, and how care ethics reacts to or differs from this understanding of what goods should be protected and fostered.

**Care and Autonomy**

The principle of autonomy claims that individual freedom to decide what is best for oneself is an essential good. As we saw earlier, there was an historical shift in medicine from a blind and trusting faith in paternalistic social relations to a recognition of the need to encourage and allow the will of the individual to thrive. According to the various analyses I outlined in Chapter I, this transition in the priority of values in the health care arena was precipitated by the abusive events which occurred during and after World War II. The abuse of beneficence and paternalism was supposedly justified by the interests of the collective good, defined initially in the allied countries as the preservation of democracy in the face of totalitarian tyranny, and later, as the promotion of scientific research.

An interesting parallel can be drawn between this shift in values and the dawn of individualism in the writing of Thomas Hobbes. The commonality between these two historical leanings towards the promotion of autonomy is the fact that they were both born out of either actual or perceived antagonistic social relations. Hobbes believed in the inevitability of a state of war of all against all in the presence of scarcity. It was in response to this presumed "natural" antagonism among all men which, due to competing interests, led to the domination of some over others, that the value of individualism had to be upheld by the mechanisms of a Leviathan. Individualism evolved as a paramount good due to its perceived vulnerability to other competitors.

In examining the shift in biomedical values from the authoritative paternalism of the physician to the right of the individual to assert his or her will with regard to physical
experimentation, investigation and treatment, we see that the promotion of autonomy also emerged out of antagonistic relations. It was in response to the fear of individual invasion and mistreatment that individual autonomy became viewed as a paramount value. One might debate this point and argue that it was because the integrity of the individual was perceived as inherently valuable that its protection and preservation was so adamantly attended to, rather than arguing that increased interest in individualism was a result of paternalism and a conception of antagonistic relations. The point which I am making, however, is that there is a tendency to value, and particularly to protect, individual autonomy in response to the perception of antagonistic relations between individuals.

In the previous chapter, we saw this position articulated in a weaker yet similar manner in reference to the work of Nancy Chodorow which emphasized the development of a certain conception of autonomy in response to the need to experience sexual differentiation during social development (i.e., between mothers and young boys). Jean Watson corroborates this analysis in her assessment of patriarchal patterns of thought:

[T]he dominant order of patriarchal thinking...invokes duality; a duality that sets humans in opposition to nature and the larger universe. Thus traditional, linear, oppressive thinking has conceived of a view of humans in opposition to each other; a duality that sets humans in opposition to nature in the larger universe. Thus, traditional linear thinking has conceived of a view of humans and what it means to be human; that is, to be separate, independent, distant from and in control over others, with a desire to manipulate others as well as the universe (Watson, 1989:45).

The thesis that such antagonism and differentiation leads to the development of a conception of autonomy which entails separation from others is discussed by many authors of care ethics literature. Indeed, Ratanakul previewed this point for us when he encouraged increased attention to the relationships among individuals in the interests of limiting egoism. The alternative argument is that the antagonistic paradigm is not the only way in which to conceive of human relationships and interests. As Susan Sherwin explains, "there is widespread criticism of the assumption that the role of ethics is to clarify obligations among individuals who are viewed as paradigmatically equal, independent, rational and autonomous" (Sherwin, 1994:21). This contested role of ethics is congruent with the view of morality as "a procedure.
by which to constrain generally unsympathetic competitors in a situation of overall scarcity" (Smith, 1985:242). The supposed independence of the autonomous subject extends not only to other people, but to beliefs and ideals. Ruth Smith elaborates that the liberal notion of the moral subject is one which "can somehow be defined independently of any particular commitments, values, or life plans" (Smith, 1985:242). Sherwin challenges this liberal conception in her assertion that "persons do not exist in abstraction, and moral directives to regard the details of personal life under some imaginary "veil of ignorance" are actually pernicious for ethical and political relations and experiences" (Sherwin, 1994:23).

If the concept of an autonomous individual is considered in an alternative manner, if instead of antagonistic and defensive states of nature, cooperative and interdependent dispositions are posited, individualism does not necessarily entail the same kinds of considerations as it generally does in the context of the theory of biomedical ethics. Virginia L. Warren suggests that

we need to explore alternative moral principles or values. Those we have now (except in virtue ethics) are best suited to handling conflicts over power and authority. I believe that autonomy, in particular, needs to be reconceived. In medical ethics, the principle of autonomy is most frequently used to fend off others' attempts to make one's decisions. Alternative conceptions might include self-expression (as opposed to self-mastery) (Warren, 1989:80).

Susan Mendus contributes to an alternative view of autonomy by suggesting that "unlike an ethic of justice, an ethic of care emphasizes the extent to which people are at least partly constituted by their relationships with those around them" (Mendus, 1993:19). She also makes a link between this ontological description and normative ethics: "It is these relationships which define [people's] moral responsibilities and which should therefore inform our discussions of moral and political life" (Mendus, 1993:19).

How do the consequences of such an alternative ontological conception of selfhood affect the manner in which autonomy is defined and respected in the context of biomedical ethics? According to a standard definition of autonomy, autonomous actions are those which ensue from 1) rational deliberation, 2) freedom from coercion and 3) adequate information (Mappes & Zembaty, 1991:25). As these three requirements stand, an alternative conception of autonomy might have little to challenge. It is how these three requirements are interpreted,
however, which is subject to review.

A care ethics interpretation of the components of autonomy would take issue particularly with the first of these three criteria. Whereas the first criterion, 1), requires rational - and consequently competent - deliberation, according to the tenets of care ethics, the deliberation necessary for autonomous decision-making and action may be encumbered. Lawrence Blum reports that in Carol Gilligan’s view, the self is "encumbered," to use Michael Sandel’s term (Blum, 1993:52). Blum explains, however, that there is an interesting distinction between the ways in which Sandel and Gilligan employ this term. Whereas Sandel translates "encumbrance" as the assimilation of "forms of communal identity," Gilligan employs the term to refer to specific relationships which one forms with concrete persons (Blum, 1993:52). This distinction is pertinent insofar as other approaches to moral theory do not always presume the existence of a moral subject in isolation from commitments and values (e.g., virtue theory). Likewise, some theoretical approaches (e.g., anarchism) do not posit an antagonistic relationship among individuals. Thus the way in which encumbrance is interpreted is germane to the differences among theoretical approaches. What is specific to the care ethics definition of encumbrance is how the self is perceived, not simply what values are intricately tied up in one's self-conception, nor the mere absence of antagonism.

According to Gilligan’s version of the "encumbered" individual, it is not irrational if emotional commitments to others inform part of the reasoning behind an autonomous decision. Furthermore, this encumbrance does not entail the negation of condition 2), which demands the absence of coercion. To be informed by emotional commitments to others does not necessarily imply that one is coerced by either the other people to whom one stands in relation, by emotions towards them or by emotional reactions with regard to oneself. Patricia Benner supports the first aspect of this refutation of encumbrance being equated with coercion in her statement that in a "phenomenological view of the person [the person is] viewed as related to others and necessarily defined by those relationships, therefore, concern for others is not necessarily oppositional to or competitive with self-interest" (Benner, 1989:367). Alison Jaggar supports the argument about emotions in general in her contention that "emotions...are wrongly seen as necessarily passive or involuntary responses to the world....[T]hey can be attributed only to what are sometimes called ‘whole persons,’ engaged in the ongoing activity
of social life" (Jaggar, 1989:137). Jaggar links the restrictions placed on emotion to the epistemological assumption that "truly scientific knowledge must be capable of intersubjective verification." Due to the fact that values and emotions had been defined as "variable and idiosyncratic, positivism stipulated that trustworthy knowledge could be established only by methods that neutralized the values and emotions of individual scientists" (Jaggar, 1989:130). This tendency to marginalize emotions as partial sources of knowledge or decision-making is disputed in George David Miller’s citation of Paul Lauritzen: "Emotions are essential, not ‘morally peripheral’ to the moral domain" (Miller, 1993:105). Blum supports this challenge to traditional epistemological assumptions in a possible neo-Kantian position. This position suggests that one can see

the categorical imperative essentially as a tester, rather than a generator, of maxims; the original source of maxims is allowed to lie in desires. This rejects a traditional understanding of Kant in which moral principles or actions are themselves derived from pure reason alone (Blum, 1993:55).

According to these premises, the validity of which I will not assess due to the parameters of this thesis, it follows that emotional content in what constitutes "autonomy" does not invalidate rational decision-making, nor does it imply coercion by forces alien to moral decision-making. Furthermore, with regard to the third condition of autonomy, namely adequate information, practitioners of care ethics may see the common dilemma of providing patients with full versus partial information in a different light. In general, the justification given for withholding information is the argument that the knowledge of certain facts will cause emotional reactions in patients which will result in irrational decision-making processes. In other words, beneficence trumps autonomy (in the effort, in this case, to protect autonomy). If, however, emotional reaction is included as a viable aspect of autonomous deliberation, it may follow that what is usually classified as justifiably undisclosed information will be reassessed as necessary information for an autonomous decision. Emotional reactions could be seen as important states to recognize, consider and respect, rather than as states to avoid and devalue.

Howard Leventhal corroborates this hypothesis by reporting that "the usual process of informing patients, i.e., naming medical procedures, describing how they are performed...does
not tell patients how it will effect their lives" (Benner, 1989:12). Given the connection between a care ethics interpretation of autonomy as interdependent, and the recognition and respect for emotions and affective ties among individuals, the following comment from Benner’s research is pertinent. She writes that "[i]f we understand the patient as constituting and constituted by relationships, we gain new perspective on the role of the body, of the situation, and the role of personal concerns in the processes of stress and coping" (Benner, 1989:12).

In this section I have shown how the ontological premises of care ethics with regard to the interdependent, contextual and "encumbered" nature of autonomous identity and the re-evaluation of emotional attachment and reaction result in alternative ways of interpreting and assessing autonomous ability. What this preliminary analysis indicates, and what the subsequent analyses of care ethics interpretations of the other dominant principles of principlism (of beneficence, and of justice in Chapter VII) will corroborate, is that care ethics does not merely entail a different emotive and affective response on the part of the health care practitioner towards the patient. Rather, care ethics asserts an alternative conception of autonomy, and re-evaluates the worth and importance of emotions. In the language of Beauchamp and Childress (Beauchamp & Childress, 1994), this means that care ethics "specifies" principles differently than do other moral approaches. In the following sections I will look at how care ethics specifies the other principles of principlism.

**Care and Beneficence**

At first glance it might seem that care ethics is naturally most closely associated with beneficence. The words "to care for" are treated as similar to the words "to treat someone beneficently." As I have argued above, however, this connection between care ethics and beneficence is due largely to the co-option of Gilligan’s terminology by some feminist writers and by the nursing profession. With regard to part of the feminist literature, Gilligan’s differentiation between two different voices, which was mistakenly interpreted by some critics to imply that women implicitly spoke with one voice and men with the other (an essentialist, biological rather than a socio-cultural interpretation), led to the argument that care ethics referred specifically to the caring behaviour of women in the household. With regard to the
nursing profession's use of Gilligan's terminology, a similar co-option has occurred. Care ethics has become synonymous with an overall professional method of conceiving and manifesting patient care, as opposed to connoting a different ontology and evaluation of emotions. This professional perspective has two very divergent interpretations. On the one hand, there is a consequentialist trend according to which much of the research done on "care ethics" looks at how caring behaviour can enhance patient well-being and recovery. On the other hand, there is a deontological approach which claims that the ideal of "caring" is the fundamental principle of nursing from which all caring action derives. The second of these aspects of the nursing perceptions of care ethics will be discussed later with regard to the grand-theory versus anti-theory debate presented earlier in Chapter III. In particular, the second aspect of nursing perceptions of care echoes Ratanakul's explication of compassion and its relevance to principles.

From the first of these two nursing approaches to care ethics, which takes a consequentialist approach by deriving care ethics from patient well-being, it follows that there is an important distinction to be drawn between looking at the interpretations that care ethics could give to the concept of beneficence, and looking at care ethics as an expression of beneficence, as one branch of the nursing literature does. Sherwin refers to the derivative definition of care ethics when she states that "there is frequent mention of the need to engage considerations of caring in medical ethics, usually couched in the language of the beneficence which is owed to patients" (Sherwin, 1992:19). Let us look at this interpretation of care in more detail.

Looking at health care in terms of nurses' professional rights, Susan Reverby reports that nurses assert the right to care (in a way not prescribed by the medical profession) on the basis of the fact that caring behaviour benefits the patient (Reverby, 1987:7). This claim elucidates our earlier discussion with regard to the use of the care ethics terminology to promote professional recognition. In other words, seen more philosophically, the endorsement and promotion by nurses of care ethics is based on the premise that caring is owed to patients due to the definitions of the healing professions themselves. If patient good is seen as one of the defining goals of the nursing profession, it follows that if caring behaviour leads to patient good, then that caring behaviour ought to be manifested. Kathleen Valentine assures us that,
although the effects of care have often been left out of cost-effective decision-making due to the fact that they are difficult to quantify, in fact, empirical analyses indicate that the benefit of caring to the patient can be measured. Such analyses define the care they examine as teaching, communication, physical touch, nurse knowledge, integrity and honesty, etc. (Valentine, 1989:31).

Joyceen S. Boyle explains that nursing theorists C. Roy, M.E. Levine and M. Rogers justify caring in terms of its utility in maintaining health and alleviating pain (Boyle, 1988:40). This accords with the definition of illness quoted in Residential Nurses and Health (1988:11) which reads, "medical practice must reflect the truth that illness is an intensely personal and interpersonal phenomenon (Jevne & Oberle, 1993:4). Helen Bequeart Holmes supports this definition, and consequently, supports nursing theorists' justification of caring behaviour, in her claim that "when someone is deeply distressed about the health of a loved one, the help most wanted is true caring (empathy, a listening ear, concern about comfort and pain, scrupulous assessment of risks/benefits, etc.)" (Bequeart Holmes, 1992:2). What is most wanted by a patient does not necessarily entail what is best for the patient; however, where something is beneficial and desired, the desire for it contributes to its beneficial effects.

Sara T. Fry makes an observation about the difference between earlier and more recent views of nursing ethics. The traditional view of nursing was that it was a part of feminine etiquette. More modern analyses view nursing as a subset of contemporary medical ethics.


As a consequence of the facts stated in Fry's analysis, the movement in the nursing profession to re-evaluate the importance of care is conforming to categories of biomedical ethics. As we saw above, caring techniques are being endorsed on the basis of their classification in the category of beneficence, contributing, it is posited, to the well-being of the patient.

Due to this kind of conformity to principlism, the proponents of care run a risk. If qualitative analysis fails to indicate the beneficial results of caring behaviour, the grounds are
lost for identifying care as an essential component of nursing. Jean Watson makes a relevant point in her explanation that "medical science and curing has been positioned as the highest order of power and control over patients and health-illness, rendering nurses' (and women's) work of caring as a means to the physician's goal of cure" (Watson, 1989:46). Madeleine Leininger implicitly supports this hierarchical relationship between curing and caring in her statement that "caring acts and decisions make the crucial difference in effective curing consequences. Therefore, it is caring that is the most essential and critical ingredient to any curative process" (Leininger, 1977:2). Although Leininger no doubt intends to assert the primacy of caring by virtue of this statement, in fact, she maintains the derivative position of caring to that of curing: even if caring is the most essential aspect of curing, curing can still be the undisputed primary goal of health care.

I suggest that what is at issue here is how curing is defined. If it is defined at least in some cases as that which results from caring, then Leininger's intended reversal of priority is viable. If curing is defined as the absence of disease and infirmity, then irrespective of how caring is seen as a means to that end, it is nevertheless subordinate. Certainly, it is this kind of re-definition of care that Leininger is essentially supporting. In fact, the sentences which Diana Gendron uses to introduce Leininger’s position read like this: "Nurses too, are showing concern. Nursing authors cite the dangers of depersonalization in health care today and the need to re-emphasize the importance of caring" [Leininger, M., 1981, Roach, M.S., 1984; Strawn, J.M., 1983; Watson, J. 1985] (Gendron, 1988:2). In other words, the reasons given here for the need to re-assert the importance of caring have to do with separation and disconnectedness, not with the deficiency of curing to cure. Thus the answer to the dilemmas nurses identify is not to support curing but to redefine it such that issues of "depersonalization" become states to cure. Gendron makes this point more clear in her report that

[health care is becoming progressively more specialized and technological. The potential is therefore great for nurses to de-emphasize humanistic care by disregarding the importance of communicating a feeling of caring through their verbal and nonverbal behaviours (Gendron, 1988:1).]

Stated in other terms, Gendron’s point is that cure is becoming defined more and more along terms which not only definitionally exclude caring from being able to cure, but also tend to
disregard care as a catalyst for curing - as it is technologically defined. Sally Gadow examines exactly this issue when she reveals that she "will invert [the] relationship between cure and care, designating care as the highest form of commitment to patients" which will entail "encompassing as many different expressions of concern for patient well-being as we are imaginative enough to devise" (Gadow, 1988:5). Gadow completely reverses the approaches reviewed above. She claims that

[i]n the usual view, of course cure is the standard, the overriding goal, and care is nothing but a means toward that end. In my view, care is the moral end, and cure is only a means to that end; more often it is a detour from which we may not find our way back to the patient (Gadow, 1988:7).

Jacinthe Pepin concurs. According to Ehrenreich and English (1978), she explains, "with the growth of scientific and technological knowledge the types of caring activities have changed." This is evident in the fact that the "'scientific' or 'specialized' aspect of caring has been separated from the more human, 'non-scientific' aspect" (Pepin, 1992:128). This separation need not, however, be the case. The definition of what constitutes cure, the goal of health care, or patient beneficence is the result of an evolution. From the historical analyses we have looked at, metamorphoses in the ideology of health care are evident. In the development of biomedical principles discussed in Chapter I, we saw a shift from health care as a paternalistic practice to health care as an institution governed by individual rights and entitlements. In David J.Rothman's historical analysis, we saw a progression from reliance on, and trust in, close personal relationships with physicians to the need to grasp onto rules and regulations. And in the nursing analysis, we see the thesis that the definition of cure has evolved from one of caring practices to one in which technological achievement is paramount. In other words, the ideals of health care have been superseded by the goals of medicine. Medical ethics has displaced health care ethics.

It is the reversal of this evolution that Gadow's line of thinking intends. Mary Carolyn Cooper suggests that a renaissance of the nursing ideal of patient beneficence is possible. She states that "care and technology have the potential to be at cross-purposes, although this is not a necessary condition of their relationship" (Cooper, 1991:29). Evidence of the potentiality for this revision, is Watson's reference to Daniel Callahan and Sally Gadow's "compelling cases
for an ethics of care/caring that help to synthesize care and cure" (Watson, 1988:2). Rather than a synthesis like the one reviewed above in which caring is reintroduced as a means or an aid to the completion of technological curing, in Callahan and Gadow's work "care is not proposed as simply a secondary fall-back position when cure is impossible" (Watson, 1988:2).

I submit that, consistent with my interpretation of the care ethics terminology, the optic of care ethics should serve as a reinterpretation or specification of what constitutes beneficence rather than as an attempt to justify caring behaviour. As I have emphasized, the consequentialist line of argument which promotes caring techniques is significantly different from the line of thinking which posits alternative premises to the ones currently endorsed by the dominant discourse of biomedical ethics. I suggest that positing these alternative premises leads to renewed specification of principles and offers the potential for recognizing alternative ones. This is the approach which I define as characteristic of care ethics. Although a re-specification on the basis of alternative premises may result in the call for more caring techniques, the promotion of these techniques strictly on the basis of their contribution to unexamined specifications of commonly espoused principles is not a viable route for proponents of care ethics to take. Again, I suspect the distinction between these divergent approaches is due to a misleading co-option of terminology, as opposed to being due to distracted enthusiasts of care ethics. Even if this is the case, however, and even if I appear to be knocking down a straw woman, the confusion which multiple and incompatible uses of the terminology engenders deserves clarification.

Let us look a little more specifically at how the alternative premises which care ethics posits could effect the way in which beneficence is specified. In its most conservative and medical oriented interpretation, beneficence refers to "biomedical good" or "medical intervention modifying the natural history of disease in a patient" [Pellegrino, 1985:21] (Sara Fry, 1992:100). In other words, beneficence entails physical cure or the alleviation of physical symptoms. There have already been attempts by prominent authors in the biomedical ethics literature to specify this principle differently. Edmund Pellegrino, for instance, adds two other components to the medical model of curing. His second definition of beneficence includes what patients themselves view as their own good. This is essentially a validation of autonomy; however, the explanation for Pellegrino's disguise of autonomy is his belief in a more grand-
theoretical scheme in which beneficence is paramount and autonomy derivative. His third conception of beneficence, and the one which is of interest to this examination, is what he calls the "good most proper to a human being" (Fry, 1992:100). This interpretation of beneficence entails

the capacity to make choices, to set up a life plan, and to determine one's goals for a satisfactory life. It is whatever fulfils our potentialities as individuals of a rational nature, respects patient dignity, and expresses human freedom (Fry, 1992:100).

Fry criticizes Pellegrino's unusually broadminded explanation of beneficence on grounds familiar to us from the preceding discussion. She asserts that the way in which Pellegrino wants to employ caring to "operationalize patient good" renders care a mere mechanism. Fry's position here, which I endorse, is that "caring is more than a mere behaviour between nurse and patient and might not always be derived from a notion of patient good" (Fry, 1994:100). However, claiming that caring is employed to further patient good is different from the above argument that caring is a means to promote curing. In other words, if patient good is defined in terms consistent with the premises that care ethics espouses, then caring is not necessarily derivative. My point, however, is that the mechanisms of "caring" are not essential to this topic. What is at issue is the way in which a care perspective would redefine the accepted principles and ideals of biomedical ethics. I agree with Fry that there is more to the care perspective than operationalizing patient good. What I mean by "more" however, is that the tenets of care ethics permeate all of biomedical ethics rather than merely those associated with patient good.

An example of how beneficence could be reconceived through the care ethics lens is evident in Gadow's definition: "The covenant of care I have in mind is the commitment to alleviating another's vulnerability" (Gadow, 1988:7). In response to the potential criticism that this is consistent with everything a physician does, Gadow hastens to add, "The treatment measures that first come to mind as the most dramatic efforts to alleviate vulnerability - for example, surgical interventions - are actually the least consistent with the concept I am proposing" (Gadow, 1988:7). Thus for Gadow, the paramount dilemma in health care is not life or death, but rather, the difference between intensifying as opposed to acknowledging and addressing vulnerability. At first blush, this definition seems to have shades of Pellegrino's
third interpretation of beneficence ("the good most proper to a human being"). Gadow continues, however. She explains that

the question is not whether to hold onto or let go of life, but whether or not to hold or let go of the special covenantal relationship of caring. Giving up on cure and giving in to death need not mean letting go of that relationship (Gadow, 1988:14).

The premises of care ethics are evident here. We can easily recognize the familiar theme of connected ontology and the value of relationship. The intention of the health care professional and the patient is not seen as one of "fixing" the patient, but rather as one of trust and comfort during a time, not necessarily of diminished autonomy, but rather of increased feelings of vulnerability. Thus again, emotional issues are given a valued place. Rather than speaking of restoring full "autonomy" and "rational" life plans to an "encumbered" (in the negative sense) individual, as Pellegrino puts it, Gadow speaks of protecting and being available to an individual who is autonomous yet vulnerable. This point is made poignant by Eugenie Gatens-Robinson and Vilia Tarvydas with regard to the perspective of the disabled community.

What the medical paradigm fails to do in Hahn's view is to take seriously the possibility that a disability might actually be a source of creativity, a source of dignity and pride [Hahn, 1989:102]. A paradigm that focuses exclusively on eradication of disability is a clear threat to those who have come to identify with their disability (Gatens-Robinson & Tarvydas, 1992:30).

What this statement elucidates is the possibility that a vision of biological perfection and longevity as the exclusive goal of beneficent intervention may actually be harmful. Gatens-Robinson and Tarvydas explain this phenomenon as an effect of the endorsement of "romantic individualism." This individualism views "dependency of any sort...as a failure to reach a totally mature adult existence" (Gatens-Robinson & Tarvydas, 1992:30). Here we see shades of Kohlberg's six-step vision of moral development which veers the agent away from considerations of relationships and dependency and towards considerations of abstract rules and principles. If dependence on one another is accepted as an integral aspect of the autonomous adult experience, it no longer becomes something to rectify in the name of beneficence. Rather, beneficence necessarily becomes re-specified as a principle which must serve to enhance cooperative relationships and to value patients' interdependence and emotional vulnerability,
whether or not their physical bodies can be "cured."

From the above observations, I conclude that the essential contribution care ethics has to make to biomedical ethics does not lie in the methods of "caring behaviour" which may lead to increased patient cure or patient good. Rather, I argue that the ontological premises of care ethics, its estimation of the high value of emotional ties and its acknowledgement of encumbrance in autonomy result in the re-specification of beneficence. Such redefinition results in the revision of the concept of "cure" to include care, or perhaps the refutation of the terminology of curing in favour of that of caring, in which curing must, of course, still be included.

Conclusion

In this chapter I have given analyses of how two of the four principles of conventional principlism (according to Beauchamp & Childress, 1994) could be revised in harmony with the tenets of care ethics. With regard to the principle of autonomy, I have shown how the premises of interdependent and cooperative individuals and the moral inclusion of emotions give rise to the conclusion that autonomy does not require unencumbered rationality and the absence of persuasive emotional commitments to oneself or to others. With regard to the principle of beneficence, I have demonstrated that care ethics requires the reinterpretation of beneficence in light of what it is to be considered a whole human being rather than merely a functioning physical organism. This mandate of care ethics is significantly different from the view that care ethics entails simple inclusion of caring techniques in the service of the ideology of curing.

From these exegeses, it can already be seen that care ethics tends to have components which are both constitutive and derivative. The premises it posits are constitutive, but the way in which it specifies the principles of the dominant model of biomedical ethics can be seen as derivative. In other words, when applied to this model, the consequences of a care ethics perspective may appear to be derived from the principles which principlism endorses. In fact, however, it is the constitutive basis of care ethics which necessitates the reinterpretation of these principles. It follows that the results of looking at principlism through a care ethics lens are derived from care ethics' constitutive premises, as opposed to from the concept of
autonomy or beneficence per se. This explanation of the constitutive nature of care ethics differs from the view endorsed by nursing ethicists, such as Fry and Watson, in which the primacy of caring is assumed. Fry’s and Watson’s positions are not synonymous with some of the statements we looked at earlier which promote caring behaviour. Rather, their respective views suggest that the ideal of caring, the impulse and obligation to care, are primary.

It is the assertion of the primacy of the ideal of caring which we will look at in more detail in Chapter VII. The relationship between this claim and the principle of justice is one which is essential to the discourse and legitimacy of care ethics. Additional premises of care ethics, including the imperative to pay attention to contextual details as well as to the particular, as opposed to the generic, individual, have profound implications for the principle of justice and the values of impartiality and universalizability. Again, as we saw hints of earlier, there is a debate as to the constitutive versus the derivative status of care ethics with regard to considerations of justice. Although as I have just pointed out, what is suggested as constitutive is different from what is, in fact, promoted as constitutive with regard to the principle of beneficence, the hierarchical argument is nonetheless present. Again, I will argue that this dichotomous vision of constitutive versus derivative is not seminal to the perspective of care ethics. What is at issue is what is valued, not whether considerations of care ethics follow from those of various principles or theories.

In the following chapter, I will address another false dichotomy which attempts to relegate care ethics to a Cinderella’s basement. This dichotomy, which claims that care ethics’ place is in the domestic sphere, is based on the false premise that care ethics is based on feelings (Chapter IV), and therefore, that it can only exist among intimates. From a rejection of this premise, and from a closer examination of what factors are the veritable guides to health care professional/patient relations, I will argue that it is the particular states of, and the power dynamic between, the individuals in the relationship which determine the appropriateness of care ethics.
CHAPTER VI

Care in Personal Vs. Impersonal Relationships: Professional Relations

Introduction

In the previous chapter, I presented the interconnectedness interpretation of autonomy and considered the effect it has on considerations of beneficence. The notion that relationships are essential aspects of moral dilemmas is fundamental to these discussions. The kind of relationship we looked at was one in which an individual sees herself as interdependent with, and emotionally bound to others.

A further way in which the notion of relationship impacts on ethics is in terms of professional/client relationships. These relationships do not necessarily have a place in an individual's core conception of his or her autonomy; they have an external impact on the individuals involved as opposed to a constitutive, subjective, internal effect. The nature of such relationships in the context of decision-making and care-taking has a significant impact on the moral considerations which are brought to bear in such situations.

As I argued in parts of Chapters IV and V, what I understand under "care ethics" is not an ethic in which moral agency and normative claims are generated from personal emotions and caring feelings. Rather, the ethics of care is an ethic which accords attention to and respect for emotional attachments and relationships. According to my interpretation of care ethics, one of the criticisms it often receives - that it cannot exit the private or domestic sphere - can be adequately addressed. The premise of this criticism is that caring feelings can only really exist among intimates, as opposed to among strangers; consequently, care as the basis for an ethic cannot be extended to the public realm. My rejection of this argument derives from my rejection of care ethics as based merely on feelings. It does not negate the argument that the nature of relationships, (for instance whether they are among friends, between parents and children, between professionals and their clients, or between certain professionals, such as nurses or doctors and their patients,) affects the kind of moral considerations which are invoked in a particular, or in a set of, moral situations. In the following discussion, I will elucidate
ways in which care ethics can meet concerns about public and private morality, and will look at how the nature of professional/patient relationships impacts this dilemma.

**Care in Private Vs. Public Morality**

In its crudest form, the general argument from universalism against care ethics refers us back to the citations given in Chapter IV in which emotions and feelings were contrasted with the positivistic, intersubjectively verifiable, scientific rationality of reason. Emotions and feelings are traditionally considered, as Jaggar points out, to be merely personal, unique, subjective experiences, and consequently, they are viewed as impositions on, and impediments to, universalistic and objective explanation and application. Because of this assumption, emotional reactions and emotive attitudes are relegated, in theory, to the private sphere where political jurisdiction is proscribed. What this compartmentalization entails is that formal political relations are governed by universalistic principles and policies, and that social and personal relations are guided by feelings and emotional attachments. We saw this position briefly in Engelhardt’s distinction between two levels of language: the universalistic secularized pluralistic language of public society, and the multiple particular languages of the private realm (Chapter III).

In addition to this argument from intersubjective verification, there is another contention which effectively quarantines care ethics to the private sphere. This is an argument which even Nel Noddings, one of the founding mothers of care ethics, supports. The argument suggests that caring can only take place between individuals in reciprocal relationships, and consequently, that care ethics cannot be made public inasmuch as public relationships are characterized by distance and impersonality. Noddings’ claim that direct reciprocity is essential to caring relationships is contested by other theorists. Both Diane Curtin and Margaret Sowerby argue that the requirement of reciprocity for caring relationships may even negate, rather than constitute, caring relationships themselves. If I care for you only because I will receive something in return, I lose the option of caring for entities from which I can expect nothing. Curtin and Sowerby want to retain the option to extend care even to objects incapable of reciprocity, such as animals and natural entities (Curtin, 1991:67; Sowerby, 1994:58).
The reciprocity requirement, which is elemental not only to Noddings' conception of care ethics, but also to other aspects of moral theories, in particular to rights theory, confines these moral systems unnecessarily. If rights, for instance, are narrowly construed such that to have a right entails being able to perform the corresponding duty or obligation, nothing without the autonomous ability to reciprocate in the system can have any claims. Of course the standard method of dealing with this shortcoming is to appoint proxies in the case of people and animals (and now, as suggested by Christopher Stone, (1986), in the case of natural entities).

The reciprocity that Noddings endorses, however, requires more than having the capacity (or a proxy) to reciprocate. The reciprocity she describes also requires localization - the simultaneous physical presence of the care-giver and the care-receiver. The requirement of localization does not in and of itself entail the restriction of care ethics to the private sphere due to the fact that local relations can be public as well as private. What localization does entail, however, is that care ethics is not, according to Noddings, a theory or approach that can be adopted and employed in an abstract fashion, as, for instance, in a social policy, a government regulation or an international law.

As we saw earlier, Noddings' vision of care ethics is predicated on the belief that such an ethic is based on caring feelings and intentions. Thus it comprises emotive responses and beneficent attitudes. I have already disputed this interpretation of care ethics, beginning, as I do, from an extension of Gilligan's experimentation. Although I think that, in some cases, the emotional response to care about others is indispensable to promoting such an ethic, I do not think that it is a requirement which is exclusive to care ethics. I also think the emotional response to care about others is important for many ethical systems, including such systems as Kantian ones. Kantian philosophies are generally perceived to embody the antithesis to care ethics because of their obsession with categorical duties and principles (Blum, 1994:217-236). In contrast, I suggest that one must sometimes care even about the implications of an abstract principle in order to carry out actions in accordance with it (Chapter IV).

Sowerby voices her objections to Noddings in a vein similar to mine. She claims that "in actuality, we decide whether to engage in caring relations, or simply to care, based on something deeper and more abstract than localization" (Sowerby, 1994:55). Sowerby identifies this deeper something as an ideal, or vision of oneself in relation to others. She writes: "[I]t
is my ethical ideal of myself as a caring person that is working when I cross the street to help an injured person or an injured cat or bird" (Sowerby, 1994:55). This ideal is what can prevent Noddings' ethics from "shrinkage," i.e., the inability to be applied abstractly in cases where the implications of an agent's action on another are not direct (Sowerby, 1994:46). Indeed, in a world where hardly anything is direct in political terms, where there is no direct representation and no finite borders to the implications of each action (be it even drinking a cup of coffee from Starbucks, (Utne Reader, Nov./Dec. 1994)), the ethics Noddings promotes must perforce be very narrow in its application. Indeed, Noddings developed her ethics specifically in response to the relationships she observed locally in the educational setting of particular schools.

From this exegesis, it is easy to understand the tendency to divide the public and the private spheres, and to relegate care and emotions to one, and abstraction and universalism to the other. Noddings promotes this division, as in fact, Sowerby unintentionally does as well. Sowerby tries to bring the ideal of caring into the public realm, but she does not contest the association of the public with the abstract. I maintain that the association between care and the private realm and between impartiality and the public realm is a faulty association in the first place. Even in the private realm, in the relationships between a father and his three children, for example, the universalist claims of equality have a very relevant place in the father's care and love for his progeny. Even though the relations are localized, as well as reciprocal, the need for fairness, which necessarily abstracts at least somewhat from the actual feelings and emotions the father has for his children, must be acknowledged. Insofar as these children are all equally his, or at least his to take care of, (be they adopted or step-children), his care for them must be equitable. Even if his love for one or the other seems to take precedence, it should not be acted on.

Chenyang Li brings the opposite perspective to bear on the issue of the dichotomy between the private and the public. Comparing aspects of the ethics of care with Confucianism, she explains that in Confucianism, just as there is no contract within the family, there is no contract in society either. Both managing a family and managing society are effected according to similar procedures. The Western division between public and private is unknown to the Confucian system. Relating this understanding of social relations to various feminist visions,
Li refers to the observations of Virginia Held. Held attacks the assumption that human beings are independent, self-interested or mutually disinterested individuals. She believes that "relations between mothers and children should be thought of as primary, and the sort of human relation all other human relations should resemble or reflect" [Held, 1987:114-115]. The relation between mothers and children is to a large extent nonvoluntary and hence noncontractual (Li, 1994:71).

This view is reflected in comments extracted earlier from Robin West’s report on a feminist conception of care derived from relations of inequality, rather than from antagonistic relations derived from supposed equality.

The position which Li and West espouse is incompatible with Susan Mendus’ view. Mendus not only suggests that the association of women with care has romantic overtones, as I alluded earlier, and as we saw exemplified in the intuitive conceptions of care shared by many women; she also claims that this association is dangerous due to its implied conceptual link between maternal and political virtues. Mendus provides a clear contrast to Li’s report of the Confucian position when she claims that the disanalogies between maternal and political virtues are "striking." Among the differences between the two types of relations, Mendus lists intimacy and inequality, which characterize maternal, but not political relations (Mendus, 1993:20-21). Rather than coming to the conclusion that intimate and unequal relations encourage caring and benevolence, Mendus assumes that such relations will promote the inequality on which they are allegedly premised.

What I argue may be the case is that in modern, western, parental relations, the intimacy by which such relations are ideally characterized impedes their inequality from being abused. In other words, caring results from inequality and intimacy combined. After all, parents do not routinely make their children slaves, or use them solely for their own purposes. Thus it is evident that Mendus is hasty in assuming that the mere existence of inequality necessarily results in hierarchical relations of power and exploitation. If the connection between care, inequality and intimacy is correct, Mendus’ point might be better understood by suggesting that since political relations are not characterized by intimacy, the care which results in unequal, yet intimate relations will not necessarily be engendered in unequal, impersonal relations.

This reformulation of Mendus’ point squares with her later focus on intimacy:
By urging the centrality of face-to-face relationships, proponents of the ethics of care hope to render political life an extension of family life. This may be an appropriate aim in societies which are small-scale, and where face-to-face relationships are the norm. But in large, anonymous, post-industrial societies the analogy becomes diminishingly useful or plausible. In brief, an ethic of care seems best suited to small-scale societies where face-to-face relationships are the norm....Modern society is large, sprawling, and anonymous. And whilst we might wish that it were not so, the insistence on an ethics which emphasises actual relationships may nevertheless appear nostalgic and untrue to the realities of modern life (Mendus, 1993:21).

Mendus emphasizes her opinion that in modern society, Li’s and Held’s vision of an ethics premised on the intimacy of relationships is impossible. She associates the desire for this return to face-to-face relationships with other movements such as socialism. Referring to the work of David George Miller, Mendus writes,

socialism became a popular ideology in response to the breakup of traditional communities under the impact of the industrial revolution. It became popular because it promised to restore the coherent moral life found in disappearing communities, whilst at the same time providing all the material (and other benefits) of industrialization (Mendus, 1993:21).

The promise of such ideologies, Mendus concludes, is impossible. We cannot restore a sense of community and connectedness without revolutionizing western societies. I think this is true only to a certain extent. Just because current societies are enormous and therefore necessarily impersonal, it does not follow that no attempt can be made to provide more opportunities for face-to-face relations, both socially and politically. The current trends towards community health care in some Canadian provinces, for instance, testify to this fact.

Despite the implications of the above excerpts from her work, Mendus does not, in fact, abandon her belief in the strength and value of human relatedness and care. What she does is reinterpret the existence of universal principles of generic equality and impartiality. She elaborates: "Perhaps our problem is not simply that it is psychologically difficult to care for those who are distant from and unknown to us, but rather that care may be morally transformed when it is extended to such contexts" (Mendus, 1993:22). I concur with Mendus and maintain that this observation is paramount. Rather than viewing universal principles and abstract notions of equality and justice as an imposition on, and refutation of, the virtues of
relationships and emotional ties, they can be reinterpreted as an extension of these aspects of private ethics to the public realm. This is a sense in which the ethics of care can indeed be viewed as primary.

Mendus puts the point as follows. She suggests that "the ethics of care draws our attention to qualities which are prominent in dealing with those whom we know and love, and it urges that, via an extension of sympathy, those same qualities may be extended to unknown others" (Mendus, 1993:22). Expressing it in this manner, Mendus reveals her perception of care ethics as an ethic which encourages the enlargement of human sympathy. I do not agree that this is exactly what the ethics of care is. However, it may be the case that a justice-based ethics, to use Gilligan's terminology, can be seen as a derivative of care ethics, and that in this sense, care ethics encourages the enlargement of human sympathy. In essence, what can be said, in conjunction with my earlier comments in response to Mendus, is that the promotion of ideologies of generic equality and impartial justice are a remedy for the lack of intimacy in unequal relationships.

Richard Rorty concurs with the idea that caring feelings and attitudes are not sufficient for impersonal relations. He uses a refutation of the notion of universal Christian love to make his point. He argues against the Christian view that it is "part of the...idea of moral perfection to treat everyone, even the guards at Auschwitz or in the Gulag, as a fellow sinner" (Rorty, 1991:191). This Christian ideal is implicit in secular theories as well, such as Kant's categorical imperative (Kymlicka, 1993:12). In Kant's philosophy, one must treat others well not because they are relatives or neighbours, but simply because they are rational beings (Rorty, 1991:191). Rorty claims that his position is incompatible with such universalistic attitudes. It is not that he disagrees with the ideal of extending sentiment as far as possible. As he explains, "my position is not incompatible with urging that we try to extend our sense of 'we' to people whom we have previously thought of as 'they'" (Rorty, 1991:192). The essence of Rorty's claim is that the incantation of moral idioms in order to rationally encourage sentiments to migrate further into the public sphere is futile. Feelings can extend to a certain degree for reasons other than rational duty, but they do not reach to every human being just because of his or her membership in the human race.

Michael Ignatieff corroborates Rorty's belief that ethics cannot be adequately driven by
abstract principles of universal commonality and fraternity. Ignatieff explains that we "recognize our humanity in our difference, in our individuality, our history, in the faithful discharge of our particular culture of obligations." Consequently, "there is no such thing as love of the human race, only the love of this person for that, in this time and not in any other" (Ignatieff, 1984:42).

Ignatieff's position is reflected in Mendus' comments that "it is not mere imagination, but logic, which precludes [care ethics'] extension beyond friends and family" (Mendus, 1993:23). As Ignatieff recognizes, it is impossible to extend caring sentiments emotively to the entire population. Compatible with Ignatieff's observation, Mendus writes that the development of justice ethics in the public sphere "need not be motivated by scepticism about peoples' willingness to extend care to a wider public" (Mendus, 1993:23).

Robin S. Dillon implies agreement with these premises stating that,

care is...not something we could or probably even should extend to those who stand outside our networks of personal relationships. Although care and personal relationships I would argue clearly have moral significance, nevertheless since care is not universalizable, we would be hard pressed to regard it as the whole of morality or as by itself a fully adequate basis for morality. Impartiality and universality are also essential for morality; and the question then becomes how to integrate the demands of emotional connection and detached impartiality (Dillon, 1992:130).

It is important to note here that the emphasis in these quotations has gone from one in which the importance of relationships is acknowledged to one in which caring is once again interpreted as feeling. What is significant in Mendus' statements is the importance of relationships and the sentiment that is often part of them. It is not an issue of trying to extend love to every human being on the planet. It is an issue of trying to extend those values which can be respected in close relationships to those situations in which relationships are impersonal.

The failure to discern the distinction I am making is addressed in Laura Purdy's critical examination of care ethics. She explains that some of the recent feminist research on care ethics suggests that "caring will help: if we care it will be obvious what matters, what to do" (Purdy, 1994:10). It is perhaps true that caring will help insofar as indifference often does not. However, I concur with Purdy's dissension: "Caring will not automatically tell us which desires
count as good reasons for discounting another's interest" (Purdy, 1994:10). The dichotomy which is drawn between care ethics and universalism is faulty if it is based on the assumption that care ethics is based only on feelings of caring. If we understand under care ethics a perspective which values certain things differently than other theories do, then the question of universalism is moot. If, of course, the premise is that care ethics requires emotional ties to everyone, then the above claims of the impossibility of such a requirement are well-founded. If, on the other hand, as I suggest, the premise is that care ethics values the emotional commitment, and therefore the type of caring relations that can eventuate between two individuals in a personal relationship, then to satisfy the universalistic claim, it must be shown how these things of value can be recognized in impersonal relations. It is this point which Mendus makes when she reinterprets abstract justice principles as extensions of the values which care ethics espouses. And as Purdy elaborates with respect to Gilligan's famous Heinz case discussed in Chapter IV, "caring will compel us to consider the kinds of communication, compromise, and concern about long-term effects evident in Amy's resolution of the Heinz case" (Purdy, 1994:10) (Chapter IV).

**Care and Health Care Professionals**

In the discussion on the distinction between private and public realms in regard to the debate between care and universalism, we have seen a tendency to associate care with personal relationships, and impartialism with impersonal relationships. As I point out, this could be viewed in two ways: either care is repressed by masculine principles and the priority of the abstract over the particular, or, as Mendus hints, care is an ideal the fulfilment of which requires the use of principles where intimacy is unreliable or impossible. (The latter is clearly a simplistic view insofar as justice is necessary even in the private sphere of intimate caring between parents and children. Let us agree then, that it is a generalization.) In conjunction with these two ways of seeing the situation emerges the suggestion that what is valued in face-to-face relationships can be promoted more in the public sphere. More opportunities can be made for renewing such encounters and for valorizing interpersonal communication.

In the following chapter, I will look at Lawrence Blum's suggestion that no matter
what, whether in personal or impersonal relationships, caring attention to application and specification entails the primacy of care over principle. I argue that this is too simple an answer for care theorists, just as is Mendus' point that care is transformed into moral principles where face-to-face relations are no longer possible. Both of these points of view do indeed challenge the unexamined notions that universality trumps particularity, and that context and other hitherto undervalued aspects of morality are irrelevant. Yet care theorists need more than simply a conceptual reinterpretation of the power dynamics among different moral ideals. It is cold comfort to merely respond to care theorists that their work is done; that we have acknowledged the potential reinterpretation of abstraction as subordinate to the interests of care ethics; that we can all go home now. The proponent of care ethics will want more. She or he will now ask, where can we begin?

The answer to this is, of course, that the work has already begun. And as we might suspect, a natural meeting place of the private and public - the sphere of health care - is where strides in care ethics are being made. Elizabeth Peter and Ruth Gallop describe this phenomenon in a way that goes deeper into the issues debated here than does the claim that nursing, for instance, is naturally a caring profession. They make the following remarks:

The nature of the relationship in a moral dilemma, whether personal or impersonal, has been shown repeatedly to be related to the use of care considerations. This association was again supported in this investigation with personal dilemmas having higher scores than impersonal ones. This finding is important because in real-life moral reasoning, moral dilemmas tend to be distinctly personal or impersonal. In contrast, clinical relationships...are a unique balance between the personal and the impersonal (Peter & Gallop, 1994:50).

This explanation for the dual nature of clinical encounters is based on the assertion that the patient is rarely someone who is well-known to the nurse or doctor, thus causing the encounter to be impersonal; however, the health care professional soon becomes closely involved in very intimate, and often life versus death situations, thereby causing the encounter to become personal.

It is not completely evident, however, that this characterization of professional/patient relationships is accurate. In fact, it may be the case that some health care professional/patient relations are personal whereas others are impersonal. For instance, it is usually nurses who take
care of patients and communicate with them on a regular basis during their hospital stay. Furthermore, the time which a patient spends in the presence of health care professionals also defines the kind of relationship which is engendered. Personal relationships might well ensue from extended hospital stays; by short-term, but frequent, visits to the same facility; during traumatizing injuries and illnesses or through regular home care. On the other hand, some relationships between health care professionals and patients can almost by definition not be personal. Such relationships would include those in which a patient rarely visits the hospital; is there for short visits never at the same ward; visits a different drop-in clinic whenever he or she needs care, or is the least "exciting" or "traumatic" case in a given facility. Indeed, this latter category could cause not only impersonal but unpleasant or antipathetic relations. In contrast to Peter and Gallop's claim, one could take an even harder line and claim, as John Hardwig does, that the professional/client relationship falls categorically into the sphere of the impersonal (Hardwig, 1984).

The question is whether or not the impersonal professional to patient relationship should be manifested differently than the personal one. Are the above factors, e.g., length of stay, extent of injury, etc., morally relevant to the considerations which are brought to bear in a particular situation? I argue that these differences should not determine how the patient is treated. It may be that in cases of extended stay and life-threatening illnesses relationships are built between health care professionals and patients which must subsequently be respected. The establishment of trust between a nurse and patient, for instance, entails that the nurse should not transfer to another shift without giving the patient warning, confidence that she will be back again, or encouragement that the new nurse will be professional, kind and attentive. However, I suggest that the considerations which were discussed in Chapter V, which outline how the tenets of care ethics could serve to specify principles, should be applied equally wherever the situation requires, not whenever the relation is personal rather than impersonal.

The reason why it is true that the health care setting is one in which care ethics is becoming more and more important is that many of its proponents are there to support it. It is not simply because of the fact that in health care, there are both personal and impersonal relations. It may be the case that due to the way in which many nurses interact with their patients, relationships which would otherwise have remained impersonal become more
personal. This should, however, not directly affect the care considerations that are brought to bear on the case, which should not depend on the level of intimacy in the relationship. In other words, not caring about a patient should not deter a health care professional from being attentive to care considerations.

I will focus our attention more clearly on the issue of professional/client relations in order to clarify the important distinction between the similar-sounding claims that 1) care considerations derive from personal relationships, and that 2), the conceptual analysis of the relationship itself is what generates considerations of care. I will suggest that the second of these claims is more accurate. This claim suggests that the inequality which characterizes relationships in the health care setting requires more attention to care considerations.

Michael Bayles outlines five different types of professional/client relationships (Bayles, 1987). The first is one of agency. In this type of relationship, the client has most of the authority and responsibility for decisions. The professional acts on the client's behalf, or under the client's direction. Such a relationship is characterized by that of lawyers to their clients, or by employees to their employers.

The second type of relationship is the contractual relationship. This relationship implies equality among the two parties, such as among business-people.

The third kind of relationship is that of friendship. These are relations which are motivated by trust and cooperation - mutual adventure. Bayles explains that some think that the lawyer/client or physician/patient relationship should be of this kind. He argues, however, that this should not be the case. Physicians and their patients are usually not friends. There is a fee to pay. There is no affective commitment (Bayles, 1987:65). I disagree with the analogy between doctors and lawyers insofar as some countries such as Canada have social health care policies in place. Most hospital encounters are provided for by the state, thus allowing a more free relationship between professional and patient. Apart from the condition of payment, however, Bayles' analysis is largely accurate and reflects my earlier comments about the rejection of care ethics as a doctrine encouraging friendly affective attitudes as the basis for ethical relations.

The fourth category of professional/patient relations is characterized by the term "paternalism." This is the kind of relationship which was reviewed in David J. Rothman's
historical account of the evolution from reliance on paternalistic beneficence to the tyranny of autonomy.

The final relationship which Bayles describes is the fiduciary relationship. Such a dyad is premised on the understanding that the weaker party depends on the stronger one, and that consequently, the relationship requires trust. The patient must consent to, rather than choose, what occurs in such an encounter (Bayles, 1987:70).

According to these analyses, what much of the care ethics literature appears to suggest is that nurse/patient relations should be characterized by friendship. I have given my account, however, of the confusion between considerations of care and caring feelings. It is also likely that more confusion in care ethics is due to the fact that in the process of rejecting the contractual model of professional relations, the model of friendship as opposed to that of fiduciary relations was endorsed. In fact, however, from the premises of care ethics regarding the development of autonomy and the stipulation that inequality must often be the base of social relations, it is the fiduciary model which more adequately represents these claims.

Sherwin concurs with this analysis. She explains that in the context of medical ethics, it is widely recognized that the relationship between physician and patient is far from equal and that the model of contract negotiated by independent, rational agents does not provide the ideal perspective on this sort of relationship (Sherwin, 1994:21).

This inequality, she elaborates, puts the dependant in a disadvantaged position. Other prominent authors in the biomedical literature nonetheless maintain a one-dimensional view of the physician/patient relationship. Edmund Pellegrino candidly states, "the physician/patient relationship, like any relationship, is a reciprocal relationship" (Pellegrino, 1994:171).

Departing from Pellegrino’s narrow vision of the physician/patient relationship, care theorists see the necessity of being sensitive to and acknowledging the kind of vulnerability inherent in the health care professional/patient relationship. There is an aspect of vulnerability that the narrow view of the professional/patient relationship cannot identify because of its premise of equality. Fry articulates Gadow’s foundational definition of what care ethics prescribes as that which "will protect and enhance human dignity of patients receiving health care" (Fry, 1992:96). In the discussion of beneficence in Chapter V, we looked at the
difference between the notion of protecting vulnerability and Pellegrino's third conception of patient good which endorsed, among other things, respect for human dignity. It is indeed quite different to respect the autonomy that apparently exists, as opposed to acknowledging a lack of dignity beneath the veneer of autonomy, and doing what is required to re-establish it.

What I propose is that rather than emphasizing the distinction between personal and impersonal relationships as the locus for division between care and abstract principles, we acknowledge the nature of the relationship in terms of its power structure, as a relevant moral consideration. In other words, rather than deciding how to treat a patient or how to interpret relevant principles with regard to him or her on the basis of how much the relationship is personal or impersonal, one's attention should be drawn to how vulnerable the patient is given the situation and the power dynamic the situation has imposed on the relationship between the patient and the practitioner. Thus some relationships may be more friendship oriented (e.g., between a frequent hospital-goer with an uncritical condition and the professionals who regularly attend to him or her), and some more contractual (e.g., between a dentist and his or her clientele). Others will be more fiduciary (e.g., between terminally ill patients and their caregivers). The way in which the ethical principles should be specified and applied must be judged according to the nature of each circumstance.

My suggestion opens up an avenue by which to exit from the troubling distinction between public and private and from the thin conceptual methods of dealing with them. It allows us to see that because of the more sensitive perceptions care ethics allows the agent to include in ethical decision-making, it follows that different modes of treatment should be associated with different types of relationships. This conclusion clearly implies that the health care professional/patient relationship is a variable factor. It is by virtue of the tenets of care ethics, and its understanding of what constitutes individual autonomy, freedom and good, that diversity among relationships can be accommodated.

The distinction I am drawing between the state of being of the parties in relationships, on the one hand, and the classification of the relationships as personal or impersonal, on the other hand, may help care ethics to be conceived as an ethics which has a relevant place in the public sphere. Under my conception of care ethics, there is nothing inherently contradictory about care ethics being applied in the public sphere; I grant, however, that the values which
care ethics espouses are simply not as prominent in the public sphere as they are in the private sphere. Naturally, care ethics' reinterpretation of the principles of autonomy, beneficence, etc., will have bearing on the kinds of policies that are created in the public sphere with regard to human interaction. However, insofar as care ethics looks at values such as emotional commitments, feelings, relationships, vulnerability, etc., its efficiency is more prominent in spheres where attention can be given to such values. A conception of relationships and the vulnerability associated with them can begin to give care ethics a more leading role in public ethics by virtue of the fact that it can more easily address the issues of oppression and domination the identification of which the traditional formulation of principles would be unlikely to allow. Generic concepts of equality, for instance, do not make room for the vulnerability of certain groups, such as women, racial minorities, the poor, etc., just as generic concepts of individual autonomy do not take account varying degrees of vulnerability as long as the minimum requirements of consent to treatment are met. The sensitivity of care ethics to the morally relevant implications of power relationships and experiences of exposure and insecurity is thus practical for relations both among individuals as well as among groups.

**Conclusion**

In this chapter I have examined the claim that care ethics is associated with and even relegated to the private realm, and more specifically, to personal and intimate relations, and that traditional moral theories, because of their universalism and abstraction are best suited to the public sphere. I endorse Mendus' perceptive reinterpretation of the way in which we could conceive of the derivation of abstract principles from the primacy or paramount valorization of care ethics and the kinds of values it promotes. I suggest, however, that although this reinterpretation has merit, more concrete work needs to be done. It is inadequate to simply re-evaluate the duality which has been created between the private and the public, and what is considered appropriate without assessing it.

As Karen Warren points out in her exegesis of what she terms the "logic of domination," to simply promote the value of the dominated aspect of a hierarchical dyad does not challenge the dualistic framework itself (Warren, 1991). In the second section of this
chapter, I contend that the dualistic dichotomy set up between care and personal relationships on the one hand, and abstract principles and impersonal relationships on the other, is falsely premised on the idea that it is the personal or impersonal nature of the relationship itself which dictates the kind of ethic which should guide it. Instead, it is the more fundamental nature of the relationship - its status as contractual, friendly, or fiduciary - which has more bearing on what considerations are necessary in the specific situation, be it public or private. And this classification, in turn, is based on the equality, or natural or imposed imbalance of power, of each particular relationship, be it between individuals or among groups.

In the following chapter, I will look more closely at the presumption of a dichotomous relationship between considerations of care and those of justice-based theories. Finally, I will look at where principlism as envisioned by Beauchamp and Childress, and the suggestions of principlism's supposed critics, fit into the tenets of care ethics.
I indicated earlier (Chapter IV) that an examination of care ethics can be divided into two categories: epistemology and methodology. We have already looked into the epistemological aspect of care ethics, using the principles of autonomy and beneficence as fora to explain what care ethics identifies as valuable. I will now turn to the second aspect of care ethics, that of methodology.

I will use the concept of justice and the related ideals of universalism and equality as arenas for investigating the methodology of care ethics and its compatibility with the methodologies of traditional philosophical systems. The idea of justice in this chapter will not be used synonymously with the "principle" of justice found in Beauchamp and Childress' principlism. Rather, the term "justice" will be used interchangeably with the concepts of universalizability, consistency and equality.

Part of the tendency to relegate care considerations to the private realm has to do with the fact that the criteria which ethics takes into consideration (emotional commitments, relationships, etc.) are naturally found in the private realm, and according to some, do not belong in the public sphere (Chapter VI). In addition, and more importantly, the argument from the public sphere is that the methodologies of care ethics violate fundamental criteria of moral theories: justice, universality, impartiality and equality. What I will argue is that the stipulations of contextual analysis and attention to particularity do not violate these principles in a way that relegates care ethics to the domain of private morality. To make this argument, I will focus our attention again on the debate presented in Chapters I and II in which principlism was distinguished from grand theories based on static hierarchical relations among principles. Care ethics, due to its rejection of hierarchical reasoning and its endorsement of contextual analysis, may well have to stand in opposition to categorical, grand theories. It does not follow, however, that care ethics must therefore disagree with the principlism of biomedical ethics.
Indeed, as Sherwin argues, the arena of health care is one which is already much more concordant with the tenets of care ethics than is philosophical moral theory in general.

I will argue, however, that context sensitivity does not entail the rejection of a commitment to universalism and to the justice that universalism entails. In addition, there is nothing inherent in the ideals of universalism and justice which implies rigidity among principles. Thus compatibility with universalism does not entail rejecting principle-guided theories, such as principlism, as opposed to principle-driven theories which are feudally organized under a grand principle overlord. I will conclude, as I have implicitly done in Chapters IV and V, that care ethics is compatible with principlism, as long as principlism allows enough movement and metamorphosis in the specification and balancing of its principles.

**Care Ethics and Contextual Analysis**

Robin Dillon asserts that caring should not be the basis of social ethics (Chapter VI). What some proponents of care ethics suggest, however, is not that caring sentiment alone should be relied on to guide all social relations. Rather, much of the promotion of care ethics is borne out of the perception that there is no place at all, let alone a prominent place, for the values that care ethics espouses, except in the private realm. In other words, few writers endorse Mendus’ perceptive reinterpretation of principles as derived, at least retrospectively, from the values of care. Most proponents of care ethics feel that universal principles derive from a patriarchal, hierarchical, antagonistic perception of the world. Mendus strictly disagrees with this approach to the history of morality, arguing that "it is [the] emphasis on common humanity despite difference which has served women...since it has provided standards of impartiality which are necessary in the pursuit of equality" (Mendus, 1993:20).

Whichever historical analysis we favour, the fact of the matter is that principles and universalistic abstractions of equality and justice do prevail due to the socio-historical factors which have rendered them more functional than care ethics. As we saw in David J. Rothman’s evolution of bedside relations in the medical world (Chapter II), the development from small communities to mega cities, the distrust engendered due to wartime and post-wartime
experimentation, and the focus on technology and physical cure all contributed to the failure of caring relations to be morally effective. The things which had been valued were disregarded. The trusting bond between health care professionals and patients was weakened. The emotional needs of the patient were ignored. Specific interests and desires were rendered insignificant in comparison with the aspiration for technical, scientific, physical cure, as well as advances in science. Consequently, the failure of the personal relationship, and the values it fostered, necessitated remediation. This came in the form of abstract principles and rules which, as was discussed earlier, in effect were designed to counteract the absence of personal relations and intimate trusting contact between the professional and the client.

The theorists of care ethics have a different response to this situation. Although perhaps assuming that the principles in place now derive from patriarchy as opposed to from a series of circumstances and events culminating in the demise of personal connections among people of the same society, proponents of care ethics suggest a return to interpersonal connection and interdependence, rather than to a system of reliance on principles alone. We will look at the potential for this return in the last section of this chapter. Let me reiterate for now that the desire for a renewal of certain values does not entail the endorsement of a social system vacillating on the insecure basis of feelings and affective attitudes alone.

It is true that some authors assert the "primacy of caring" (Sara Fry, 1994; Jean Watson, 1989; Patricia Benner, 1989; Virginia Held, 1987). Others, however, claim that components of care ethics and of justice-based ethics must coincide. Still others suggest that care ethics is subordinate to considerations of justice ethics. In the previous section, I indicated how care ethics is perceived as unsuited to public life due to the fact that it is impossible to feel love for each and every human being, even within the boundaries of, for instance, a city - let alone a country, or the world. I argued that, once again, this criticism interprets care ethics as feeling-based, as compared to as an ethics which promotes certain things as valuable, including relationships and emotive ties. Yet there is another way in which care ethics is ostensibly deficient in relation to the criterion of universalism. Because care ethics focuses on the particular, rather than on the generic, be it in the form of a situation or a specific person, it is decried as being incompatible with universalistic principles. Purdy elaborates as follows:
Caring may lead us to focus on particular cases. Concern for particulars is an admirable antidote to the lifeless, overly broad strokes to which we have been so often subjected by moral philosophers. But I think that we must beware of any corresponding tendency to devalue principles excessively (Purdy, 1994:10).

The focus of care ethics on relationships of connectedness and trust is not something which obscures attention to broader political and social issues. Nor is care ethics’ concern for particularities parochial or apolitical. Pellegrino writes that the dominant trend in biomedical ethics to focus on claims of autonomy, or in Beauchamp and Childress’ language, to balance the principles in favour of autonomy rather than in favour of justice, tends to obscure larger political issues more than does an interest in the tenets of care ethics (Pellegrino, 1994). I suggest, as I argued in Chapter IV, that the use of care ethics to study the content and form of principles, such as autonomy, can bring important issues of social equality and justice into the foreground (Sherwin, 1994:23).

A further criticism of the importance of contextual analysis to care ethics is that to pay attention to the particular is to be committed to situation ethics. Purdy continues her criticism of care ethics by making an analogy. "Situation ethics never caught on, and for good reason. It provided no criterion for judging the quality of moral decision-making. Are we in danger of falling into the same trap" (Purdy, 1994:10)? The answer to this question is no. Attention to context, and to the particular versus the generic, person does not need to violate any moral principles. It may be true that there are instances when moral rules must be overridden. However, usually what this means is that the rule which seems to apply actually does not.

What Purdy later concludes, however, is that the kinds of techniques and focal points, which care ethics brings to bear can, in fact, be compatible with universalism in this way:

The kind of attention to close detail, circumstance and interest we think appropriate to good ethics is not incompatible with universalizability. On the contrary, if we can show why these characteristics are important, universalizability should compel every moral thinker to heed them (Purdy, 1994:11).

In fact, it is often writers other than proponents of care ethics who suggest the complete abolition of abstraction and principles. Sherwin refers to Ronald Christie and Barry Hoffmaster (1986) who take this hard line, which accords with Drane’s virtue-theory rejection of
principles. Christie and Hoffmaster argue that "general moral theory does not illuminate specific cases and therefore is not helpful" due to the fact that "the principles of moral philosophy are simply too abstract and too formal to contribute to the resolution of concrete cases" (Sherwin, 1994:20).

In care ethics, on the other hand, the contextual analysis that is promoted does not necessarily entail this unremitting rejection of anything abstractly related to the situation at hand. Purdy’s reference to "close attention to detail, circumstance and interest" is something she associates with "good ethics," not merely with "good care ethics." Sherwin goes further than Purdy by thinking that what care ethics means by attention to detail is more than what is generally meant by these terms in general ethics; but again, what Sherwin promotes does not entail the rejection or violation of potential principles. She refers to Engelhardt’s (1986) prioritization of the obligation of beneficence. She reports that "the obligation as such is abstract. Only in concrete contexts can one determine the extent of the obligation, and how to rank the various goods that can be at stake" (Sherwin, 1994:20). She also refers to Arthur Caplan’s (1980) rejection of the notion that biomedical ethics is merely something to be "applied," an argument similar to the one we are familiar with from Henk ten Have’s criticisms explained in Chapter III. Sherwin concludes that there is a trend in the literature of biomedical ethics, to "examine issues in context and avoid dependence on general abstract rules and rights" (Sherwin, 1994:20).

In other words, in the debate between care ethics and universalism, dominant trends in biomedical ethics are closer to the camp of contextual analysis (care ethics) than to the camp of overarching theory ("justice"-based ethics (Gilligan, 1982)). Yet Sherwin underlines how even the apparent tendency for current writers in the ethics literature of biomedicine to be sensitive to the "particular" is inadequate according to care ethics. She writes,

Some philosophers still entrenched in mainstream moral theory have difficulty seeing the distinction being cited here, since surely all moral theories are context sensitive to some degree. Kantian theory, for example, demands an interpretation of context in order to determine which maxim applies in a given case. But Kantian theory does assume that the maxims, once identified, will be universal and our policy on suicide, truth-telling, or confidentiality will be consistent across the full spectrum of relevant cases. It does not direct us or make our ethical assessments in terms of particular details of the lives of the individuals
In the terminology of Beauchamp and Childress, Sherwin makes the distinction between being sensitive enough to context to discover which principles should be applied and being sensitive enough to context to balance and specify principles accordingly. An analogy can be made to legal theory. It is necessary to be at least aware of the facts and the circumstances in order to know what legal principles to draw on; however, it is in the consideration of specific details and contingent information that the sensitive judge can make a good decision. The recent case of Robert Latimer who killed his severely disabled daughter, apparently out of mercy, provides a good example of this analogy. Strictly according to the letter of the law, Latimer committed murder. With respect to the context, however, some supporters of the defendant argue that the principles of the law are too strict. Latimer killed his daughter, they agree, but this killing does not constitute a murder. As it turned out, Latimer was found guilty of second degree murder, after being charged with first. These arguments suggest that it may be necessary to create alternative principles to fit the new kinds of cases which the law encounters. Whether or not there is a change in legal categories for murder, there is also another way in which context can be taken into account. The harshness and nature of the sentence is at least partially up to the discretion of the judge and jury: the intended beneficence and mercy of Latimer’s actions are taken into account. More and more legal doctrines are coming into play in response to sensitivity to particularities and specific circumstances, even those including emotional attachments and feelings, such as the "battered wife syndrome."

Will Kymlicka also uses the arena of legal jurisprudence as a forum to examine contextual analysis in justice-based theories. He writes,

[i]t is true that most contemporary theorists of justice concentrate more on determining correct principles than on explaining how individuals become ‘equipped to act morally’ [Tronto, 1987:657]. But the former leads naturally to the latter, for the justice ethic also requires these moral dispositions. While justice involves applying correct principles, ‘what it takes to bring such principles to bear on individual situations involves qualities of character and sensibilities which are themselves moral and which go beyond the straightforward process of consulting a principle and then conforming one’s will and action to it’ [Blum, 1988:485] (Kymlicka, 1990:265).
Kymlicka goes on to discuss the capacities jurors must exemplify in the process of deciding whether certain principles and doctrines apply in specific cases.

To use Beauchamp and Childress' language, the kind of context sensitivity Sherwin identifies as particular to generic biomedical ethics and which Kymlicka identifies as part of legal jurisprudence is analogous to the balancing of principles. What is peculiar to the care ethics approach is that the balance of principles as well as their concurrent specification is important. Specification entails interpreting the principles in light of some of the methods we reviewed in Chapter V; it does not merely entail having the "moral equipment" to know which principles to bring to bear. Specification does not, however, mean that the principles themselves would be violated. On the other hand, if it were the case that for some patients autonomy was respected but for others it was not, or if it were the case that the autonomy of one patient was defined differently from that of another whose circumstances were literally identical, injustice in the form of particularism, favouritism or discrimination might be occurring.

What care ethics indicates, however, is that emphasis on generic principles tends to promote a disregard for important differences and to foster the assumption that rules and categories can adequately capture the richness of moral experience. The idea that difference cannot be acknowledged in the name of equality and impartiality is fallacious. Iris Marion Young addresses the tension between universality and the concept of sameness. She explains that in the liberal democratic attempt to give civil rights to all people, the concept of equal citizenship became politically synonymous with homogeneity. With this equation followed two stipulations, both of which Young contests.

With equality conceived as sameness, the ideal of universal citizenship carries at least two meanings in addition to the extension of citizenship to everyone: (a) universality defined as general in opposition to particular; what citizens have in common as opposed to how they differ, and (b) universality in the sense of laws and rules that say the same for all and apply to all in the same way; laws and rules that are blind to individual and group differences (Young, 1989:250).

The concept behind universalism and impartiality is that morally irrelevant differences should not be used to discriminate. Hence the dictum, everyone is equal before the law, and the definition of justice which incites like treatment of like cases. What care ethics discloses,
however, is that there are important differences that have been relegated to the private or
unpolitical sphere which are indeed relevant in legal, political and medical spheres. Nonetheless
it is still essential that the new differences that are found relevant are considered applicable to
all who share them in the same way. Ester Condon makes the point well when she writes,
"models of caring assume that the participants in a caring process are persons with histories,
values, preferences, and differences; these are expected to influence the process and outcome
of the caring encounter" (Condon, 1992:16). She continues to explain that

caring] models, which are currently of interest to nurses, seem also to reflect
what Gilligan has characterized as an ethical orientation of care, relationship and
responsibility, which emerges from seeing issues within the context of
relationships and the life situation of the particular other involved rather than in
the abstract context with some generalized other to whom fixed rules and
principles can be impartially applied in ethical situations (Condon, 1992:17).

The Primacy of Care or Universalism

As Robin Dillon corroborates, this attention to relevant differences does not reduce
ethics to relativism, nor does it violate justice.

The most powerful aspect of care respect is, I believe, its ability to maintain a
constructive tension between regarding each person as just as valuable as every
other and regarding this individual as special (Dillon, 1992:122).

Despite these trends to valorize care and justice perspectives on equal footing, Lawrence
Blum outlines many rejoinders which the impartialist universalist could give the care ethicist.
One of these is the claim that "acting from care is actually acting on perhaps complex but
nevertheless fully universalizable principles" (Blum, 1993:53). This is the strongest view of the
eight which Blum outlines. The second to last one of the series claims that

even though care considerations are distinct from universal principles and
impartiality, and while they are genuinely moral, nevertheless their ultimate
acceptability or justifiability rests on their being able to be validated or affirmed
from an impartial perspective (Blum, 1993:56).

Finally, the eighth in the series bears resemblance to the final stage of the six stages which
characterize Lawrence Kohlberg's conception of moral development, discussed in Chapter IV. This stage claims that it is the "integration of justice and care that forms a single moral principle" (Blum, 1993:57). Interestingly, criticisms have been made of Kohlberg that his sixth stage has never been documented empirically, and consequently, that it is not a relevant moral stage of development. Again, on the idealist level, however, if we are reminded of Mendus' earlier points, what care ethics values on the personal level, justice may be able to achieve on the impersonal level. Consequently, as opposed to perceiving justice as the antithesis to care, it can be understood as the extension of care where personal connection is no longer possible.

Let it by no means be mistakenly assumed that Kohlberg endorsed the symbiosis of care and justice. Rather, in general, he believed care considerations to be unquestionably inferior to the other stages of moral development which subordinate relationships to rules, as we saw in Chapter IV. Kohlberg is definitely in the "impartialist" camp. What Blum rejects is all of the "Kohlbergian" impartialist rejoinders, by showing that even if one endorsed the strongest of them, one would not be committed to impartialism and universality. Blum suggests that it is actually the ability to care which allows one to intelligently apply principles and rules. In his words, Blum explains that

knowing that the particular situation which the agent is facing is one which calls for the particular principles in question and knowing how to apply the principle in question are capacities which, in the domain of personal relations are intimately connected with care for individual persons (Blum, 1993:59).

From this premise, Blum concludes that it is no compromise with arguments from impartialism (universalism) to assert that "the role of particularity lies in the application of general role-principles to the particular case" (Blum, 1993:61). Rather, Blum claims that "the process of application itself draws on moral capacities not accounted for by impartialism alone" (Blum, 1993:61). Blum refers to the need to have knowledge both of the situation, and of what action is specified by the principle itself. These abilities are indispensable to the impartialist goal of acting according to principle. However, these abilities cannot be accounted for exclusively by an impartialist perspective (Blum, 1993:61).

At first glance, Blum's statement appears to contradict my earlier connections between attention to particularity and the fact that relevant differences do not violate universality. He
does not address this particular claim, however. Rather, he directs our attention to the capacities which allow an individual to be sensitive to subtle differences and to know what principles to apply and how to apply them. In other words, Blum reverts back to the familiar association between care and the ability to see what is at issue, as we saw in Kymlicka's example above. In the Jake and Amy dilemma, however, what was labelled "care ethics" was not merely Amy's ability to see different aspects of the situation. "Care ethics" also refers to what it was that Amy saw. As was pointed out in Chapter IV, there are two components to care ethics: the epistemological method and the criteria which are valued due to this epistemology. I argue that the epistemological criterion is not as essential to care ethics as is the question of what is at stake. Some theorists would argue that it is only because of the care epistemology that these values can be identified. If such theorists are referring to a women's way of knowing, this may be the case; however, once women's knowledge is identified and acknowledged, the epistemological means by which such knowledge was identified are not essential to each individual. What is essential in terms of epistemological method for care ethics is the tendency to value contextual analysis, particularity and non-hierarchical reasoning. Hence my agreement with Blum that a certain level of intelligence, sensitivity and attentive care to the situation at hand are necessary for correct ethical behaviour. However, I would argue that many of these criteria are essential to fulfilling the requirements of many ethical theories. If he implies that care is simply the intelligent, sensitive application of principles to situations, Blum has misunderstood the essence of Sherwin's earlier distinction between knowing the context in order to adequately apply principles, and being truly context sensitive.

Blum's focus on this epistemological function is shared by other authors who thereby assert care as primary. Sara Fry argues that caring which "must be grounded within a moral-point-of-view of persons rather than any idealized conception of moral action, moral behaviour, or system of moral justification" (Fry, 1992:94), is fundamental to nursing ethics. While she agrees that there is value in such principles as autonomy and beneficence, she explains that "neither of these values, derived from theories of medical ethics, has been convincingly argued to be the primary moral foundation of the nursing ethics" (Fry, 1992:96). Although it may appear that Fry is comparing care ethics with principilism, due to her reference to the values of autonomy and beneficence, her arguments are actually directed towards comprehensive,
hierarchically structured theories in which either one of these goods is given categorical primacy (Pellegrino and Thomasma favouring beneficence (1988); Engelhardt favouring autonomy (1986)).

Chenyang Li demonstrates how Nel Noddings' position concurs with Fry's. According to Noddings, it is caring, not the consequences of it, which establishes moral values (Li, 1994:75). This view complements the Confucian position which suggests that "things are not perfect. We cannot demand anyone to make things perfect. As long as one cares reasonably enough, morality is satisfied" (Li, 1994:75). Here again we find shades of Drane's virtue ethics position. Daniel Putnam argues that "what relational ethics is doing is attempting to move the discussion from a focus on ethical technique to an image of what the ethically mature person is" (Putnam, 1991:237). The virtue of caring is apparently enough to guide ethical action. This argument is similar to the debate which was represented in Chapter VI with regard to the reliance on universal love to guide ethics. Yet the present viewpoint adds the stipulation that the very virtue or ability to care will epistemologically address ethical dilemmas. This is synonymous with Blum's position, that something happens prior to the employment of ethical principles which is not analytically contained within the concept of universalism.

Anders Lindseth contests the above claims in his affirmation that "it is...difficult to base a normative ethics on the concept of caring. This is due to the fact that our actions do not become ethically good by virtue of being caring actions" (Lindseth, 1992:101). In other words, caring intentions are not effective as an epistemological determinant of ethical action. Later in his argument, Lindseth appears to contradict himself when he acknowledges that "relation ethics is fundamental in a particular sense: we can regard it as the base on which action ethics must be built" (Lindseth, 1992:103). What emerges from this apparent contradiction is the notion that care, the disposition and the ideal, constitutes a building block in the construction of ethical understanding. Care cannot be relied on exclusively as an emotion by which we can determine what to do. However, the kinds of considerations which care ethics generates can be used to build a more comprehensive ethical view of the world. Lindseth writes that "the responsibility of the physician often gives priority to action ethics, and the kind of continuous caring responsibility the nurses have naturally gives priority to relation ethics" (Lindseth, 1992:103). We have already reviewed this observation extensively, using different terminology.
Lindseth believes that the two natural preferences which these theories have cannot be exclusive, nor can they replace each other. What can be gleaned from Fry's comments in light of Lindseth's compromise is that epistemological reliance on caring attitudes is not what care ethics entails. Care can be admitted as foundational in collaboration with other considerations. Fry defines her position, as was demonstrated in Chapter V, in contrast with Pellegrino's assumption that care is merely a method of effecting beneficence. That care is more fundamental than this has been argued. It does not follow, however, that it is primary in the same way that the grand theorists posit the primacy of whichever ideal they perceive as foundational.

Jeannine Boyer Ross and James Lindemann Nelson share my disagreement with Fry's insistence on the primacy of care. Ross and Nelson suggest that caring's role should be understood "not as an alternative object of value, competing with autonomy or patient good, but rather as an alternative way of responding toward that which is of value" (Ross & Nelson, 1994:107). They elaborate that
caring does not parallel 'autonomy' in the principle of 'respect for autonomy';
it does not parallel 'utility' in the principle 'maximize overall utility'. What it more nearly corresponds to are the ideas of 'respect' and 'maximization', the way in which we comport ourselves regarding that which we value (Ross & Nelson, 1994:108).

At first this analysis may appear to reflect the arguments put forth by Pellegrino in which caring is perceived as a derivative of patient good. This is not the essence of Ross and Nelson's claim, however. When Ross and Nelson refer to caring as the way in which we act towards that which we value, this does not mean that care should be employed in the process of accommodating other values. Using the case of Amy and Jake as an example, Ross and Nelson explain that "[m]uch of what seems distinctive in [Amy's] response is a concern for the maintenance of relationships" and this "concern feeds a scope and a flexibility in her thinking, as well as a refusal to be beguiled by the artificial limits of Kohlberg's way of putting the case" (Ross & Nelson, 1994:108).

This point addresses the methodological component of care ethics. It identifies the non-hierarchical method of reasoning that Amy employs, and valorizes the contextual analysis she
brings to bear. Ross and Nelson's point, however, does not acknowledge the fact that care ethics identifies different things as valuable to begin with, rather than simply treating things already valued in a different way than usual.

My suggestion that care ethics posits the value of things which are often undervalued is supported in Mary Cooper's study of nurses' moral responses. Cooper reports that "nurses' moral decision making went beyond what would be dictated by a rational weighing of competing moral principles to encompass a complex, uncertain, and emotionally laden process of moral struggle" (Cooper, 1991:25). This "going beyond" does not indicate that there is something more foundational about appealing to the values which care ethics espouses, but rather, that the rational principles as they are specified are inadequate to deal with the range of issues that nurses encounter, even if, as Ross and Nelson contend, nurses may respond differently to the issues that are generally recognized by traditional categories of ethical concern.

**Conclusion**

Virginia Warren further clarifies this point. She explains that "moral philosophers need to...[decide] which moral issues merit attention" (Warren, 1994:32). This is exactly what the nurses in Cooper's case were doing. Equating feminist ethics with the introduction of the care perspective in medicine, Warren extends the idea of issue identification to the broader social context. "In addition, feminist ethics could include women's perspectives, along with perspectives of males *qua* males, and the interests of children, by posing new questions" (Warren, 1994:35). The tendency, she elaborates, of traditional philosophical ethics to focus on "crisis issues" (e.g., abortion or withdrawal of life-support), rather than on what she terms "housekeeping issues," has played an influential role in the promotion of the principles currently espoused in the biomedical literature. She explains that crisis issues are more readily handled using such standard moral principles as justice, autonomy, beneficence and non-maleficence, and utility. Applying these principles to housekeeping issues helps only up to a point. These principles do not deal satisfactorily with psychological subtleties, especially with the intricacies of longer-term relationships (Warren, 1994:38).
I would modify Warren’s point by suggesting that it is more the way in which traditional philosophy and the obsession with sensationalistic ethical cases has caused these principles to be specified and balanced which causes other paramount issues to be disregarded. Warren’s solution to the problem she identifies is that we need to explore not only new question, but also alternative moral principles or values. Those we have now are best suited to handling conflicts over power and authority. I believe that autonomy is most frequently used to fend off others’ attempts to make one’s decisions, but it may prove wanting as a positive conception of human agency at its noblest (Warren, 1994:41).

Warren’s characterization of the use of the principle of autonomy may or may not be correct; however her solution squares perfectly with my comments in Chapter V with regard to its possible re-specification. My suggestion is once again that the kind of principles and the relation among them upon which Warren premises her criticisms are in line with grand theoretical approaches, such as Pellegrino’s and Engelhardt’s, rather than in line with the principlism of Beauchamp and Childress. Nonetheless, even principlism requires the kind of new questioning and challenging which care ethics proposes. Principlism may not have to be as targeted due to its already flexible understanding of the relationship among principles, and its non-hierarchical ordering of priority among them. However, its proponents need to be educated with regard to the kind of contextual sensitivity care ethics requires, and to the kinds of questions care ethics requires the principles to address. It may be the case that in such a process, very new principles will be identified which simply cannot be accommodated by the issues which the current principles cover. For the present, however, I am convinced that there is sufficient room for a lot of work to be done without rejecting the existing principles outright.
The purpose of this thesis has been to examine the relationship between the dominant theoretical trend in biomedical ethics, namely principlism, and the alternative theoretical approach offered by care ethics. My intent has been to situate these two perspectives in the current theoretical climate of North American ethical debate, and to show where they differ from each other and where they are compatible.

In the first chapter, I provided a brief history of biomedical ethics. This was followed in Chapters II and III by critiques of "principlism," the most dominant contender among conventional biomedical ethics theories. The criticisms presented were drawn from both grand-theory and anti-theory approaches to philosophy. My analysis concluded that principlism, as envisioned by Tom L. Beauchamp and James F. Childress has evolved throughout the years to a position allied more closely with anti-theory than with grand-theory. This conclusion offered an early hint of the possible negotiations between principlism and care ethics due to the fact that care ethics is philosophically related to anti-theory.

In Chapter IV, I introduced the main tenets of care ethics and clarified some of the confusions surrounding its terminology, and the motives for its promotion. Regarding terminology, I distinguished care as an ethic from care as an affect and suggested that it valorizes emotions and relationships rather than being dependent on them. In light of motives, I investigated care ethics' potential as a philosophical partner of principlism instead of promoting it on behalf of feminism or the nursing profession.

In Chapter V, I looked at the contributions care ethics can make to the specification of two of principlism's four principles, autonomy and beneficence. Through an examination of the alternative ontology which care ethics espouses, namely one of connectedness and interdependence rather than of separation and antagonism, I suggested that care ethics can broaden the current interpretation of autonomy in important ways. With regard to the principle of beneficence, I used the disparity between the concepts of "cure" and "care" to postulate the inappropriateness of the equation of beneficence with curing as it is generally defined.
I addressed the issue of health care professional/patient relationships in Chapter VI and argued that care ethics is falsely construed as an ethic which is practicable only in personal relations. I suggested that it is not the identification of a relationship as personal or impersonal which determines the best treatment, but rather, that it is the power structure of the relationship, its nature as contractual, fiduciary, friendship, etc., which is the best indication for type of treatment.

In the last chapter of the thesis I addressed the methodology of care ethics in light of the traditionally accepted criteria for conventional philosophical theory: justice, universality, impartiality and equality. I maintained that care ethics' attention to a higher level of particularity and context does not violate standards of consistency and justice. As long as similar cases are treated in similar ways, we should not hesitate to endorse an approach which is more flexible and malleable to the particular contours of specific situations.

The analyses and arguments presented in these chapters serve to establish my contention that principlism and care ethics can exist harmoniously together, and more importantly, that their partnership is more advantageous than their mere coexistence.

Despite the significant conclusions which I have drawn from the inquiries presented in this thesis, my observations only hint at the potential distance the theory of biomedical ethics can go with the inspiration and insight a carefully formulated version of care ethics offers it. The specification and balancing of principles, and the possible formulation of new principles entirely, is a project which care ethics can continuously support.

The relevance of care ethics to this endeavour is particularly evident in the recent Royal Commission on New Reproductive Technologies (1993). In the introductory chapters of the volumes the Commission produced, and in the research volume documenting the queries it made with regard to ethical theory, it is reported that the Commission avoided the use of a "comprehensive ethical theory" such as the grand-theoretical approaches of utilitarianism or Kantianism, in favour of what they refer to as a set of "guiding principles" (RCNRT, 1993: Chapter 3; Kymlicka, 1993:2). The list of principles which the Commission finally chose by means of both theoretical and empirical investigation, is not identical to Beauchamp and Childress' quartet of principles. The Commission's principles consists of seven principles, three of which correspond to the principles of autonomy, beneficence and justice. What is interesting
about the principles the Commission's inquiry led to is that some of them appear specifically to address relationship and social issues in ways which reflect care ethics' emphasis on ontologies of connection and interdependence rather than on separation and individualism. These include the principles of "accountability," "appropriate use of resources" and "non-commercialization of reproduction" (RCNRT, 1993: Chapter 3; Kymlicka, 1993:17-25).

What is even more significant about the fact that a principlist approach is used by the Commission is that the Commission's mandate was to inform social policy rather than hospital procedure. Will Kymlicka differentiates between the conventional use of biomedical ethics as "an aid [to] individual doctors [to] deal with individual cases" and the Commission's use of biomedical ethics to define "principles by which society should be guided when managing and funding the provisions of NRTs inside and outside the health care system" (Kymlicka, 1993:26). With regard to the contentions I discussed in Chapter VI regarding personal versus impersonal relations and the private versus the public sphere, it could, albeit contentiously, be argued that relations in a hospital fall into the category of the personal and the private. Although I disagree with this position, it would not even have to be debated with regard to social policy: the concept of social relations in forming health care policy is by definition impersonal and public. Consequently, the Commission's use of a principlist approach, informed by considerations similar to the considerations promoted by care ethics, to guide social policy, is an indication both of the compatibility of principlism and care ethics, and of the appropriateness of such a combined approach not only for the private and personal realm, but also for the public and impersonal arena.

Evidently, the opportunity exists for ongoing investigations into the combined contributions of care ethics and principlism both theoretically, as this thesis has indicated, and more practically, as the RCNRT demonstrated. The contributions of care ethics to biomedical ethics should be welcomed and encouraged, not quarantined (by conventional theorists or by care ethicists themselves) into an exclusive arena. The partnership between care ethics and principlism is only in the stages of courtship. Its future lies open for further research.


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