CARING AND BIOETHICS: PERSPECTIVES, PREDICAMENTS, AND POSSIBILITIES

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ABSTRACT

This thesis presents an explorative study of the place of caring in bioethics. Through the examination of various sources of literature from the disciplines of nursing, feminist theory and ethics, and bioethics, a case is developed that argues for a valid respected place for caring, as an ethic of care in bioethical decision-making. Evidence is presented and examined from all three disciplines including critiques of caring, an ethic of care, and bioethics from all disciplinary perspectives.

The case is built by providing evidence to support the fundamental importance of caring to human life, health, relationships, and survival at the broad societal level. This is supported by more detailed and specific evidence regarding the value and the 'good' of caring and the ethical aspects of caring. This is presented from the feminist and nursing perspectives, along with a critique of the negative aspects of caring practices. The next stage of the case presents a layout of the discipline of bioethics, using an historical perspective to illuminate the influences of bioethics' deep past, as it still affects the discipline in the present. The development of contemporary bioethics' current status is presented along with critiques from bioethicists themselves, and nursing and feminist theory and ethics.

In the case at this point, from a bioethical perspective, two major predicaments appear to prevent an ethic of care obtaining a valid place in ethical decision-making in bioethics. These are the justice/care duality, and the conflict between different conceptions of care and autonomy. The bioethical objections and arguments put forward regarding these predicaments are picked up, meticulously and comprehensively examined and refuted, establishing a sound case for the inclusion of an ethic of care in bioethical decision-making.

ACKNOWLEDGEMENTS

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CHOOSING THE LENSES AND TAKING A BEARING: AN ORIENTATION TO THE THESIS

"On the road to find out" (Cat Stevens, 1979).

Introduction

The purpose of this chapter is to introduce the reader to the topic of the thesis and explain how the topic came into being, and how the investigation was organised.

Focus of thesis

This thesis is an exploration of the place of caring in bioethics. The starting point, or impetus for this thesis, stems from my assumption of the fundamental importance and ethicality of caring, in human, (and nonhuman) health, development, quality of life, and survival. This assumption I have developed in reflection and over time from a combination of knowledge, learning, and experience as a nurse and as a student. In particular, from tertiary nursing and women's studies; as a patient with a chronic disability; and as a human being who is also a woman. It has led me to hold the perspective that the profound importance of caring, and its ethical aspects, to human and nonhuman life, requires that it be included in ethical decision making particularly in the healthcare arena which is the realm of bioethics. To be even more direct I would say that I do not believe ethical decision making is actually "ethical" without including a caring perspective, that is, an ethic-of-care, into the decision making process. This thesis then proceeds with an attempt to articulate and support this perspective and the assumption it is based on by exploring and drawing from

selected sources of literature on caring and bioethics from the feminist, nursing, and bioethical perspectives.

Personal statement/reflection

The creation of this thesis has come about through the coalescing of several factors and circumstances. It begins with the combination of fourteen years' experience of nursing education and practice and twelve years' experience, education, and survival as a patient with chronic pain and disability. From this combined experience I have had the opportunity to experience and come to know deeply and profoundly, both as a nurse and patient, the fundamental importance of caring to health, human development, and quality of life, as well as the powerful and sometimes transformative healing it can produce.

My understanding of health is that an absence of disease and or disability, even the presence of a terminal condition, is not a requirement for health. Health, from my experience and understanding, consists above all of good quality relationships that involve loving and caring. They also involve a sense of belonging, a sense of self worth, a connection with the natural world and the other creatures that share it, having a vision for the future and being able to make plans that can give a reasonable chance for achieving the vision. In my view health, and caring, is often largely about helping to remove obstacles, and providing the right needs at the right time. From both sides of my nurse/patient experiences a genuine caring relationship can provide the knowledge, understanding and sensitivity necessary to know what really counts as an obstacle to a particular person in their particular context and to judge along with them the right need and the right time to move into action, or not to act, as the situation may require. From my perspective when this is achieved and caring is done well it is an extremely valuable complex skill and one that requires considerable amounts of intellect, self-knowledge and

awareness, courage, general knowledge, and experience. This level of skill also requires time, effort, commitment, ongoing learning, and reflection.

This form of caring within the profession of nursing and directed purposefully towards the health of another human being is not just a simple, easy, natural, instinctive, instantaneous occurrence, although those descriptors can all be applied in some caring situations. It has always seemed to me in nursing that the greater the caring skills, experience, and development the less obvious they are, and thus appearing simple, natural and unsophisticated, are easily overlooked by an untrained eye, and frequently go unrecognised for the artful scientific skills they really are.

Main argument

The primordial source underpinning the development of this thesis is a belief in the good of caring and a deep concern for the erosion in the valuing of caring both within nursing and on a more general societal level. The devalued status of caring is not new. It has an historical basis in long-standing philosophical and social issues and inequities. However, over the last decade there have been radical changes in the healthcare system with the implementation of neo-liberal policies of economic rationalism and the exposure of healthcare services to market forces. This has markedly heightened my concern for the exacerbation of the erosion of caring particularly in the healthcare system. This exacerbation has been clearly articulated by Jane Kelsey in her book *The New Zealand Experiment: A world model for structural adjustment?* published in a new edition in 1997. While acknowledging that caring has negative aspects, flaws, and traps for the unwary, I still believe despite this, that caring is fundamentally necessary for the quality of relationships, development, health, peace, well being, safety, and ultimately the survival of human beings. These beliefs and assumptions are both personal, deeply professional, and indubitably rooted in the social, and cultural and contextual circumstances and influences in which the personal, professional, political, gender, race, and class aspects of myself are

entwined and embedded. However, I am neither alone nor unique in my position.

I share with Bowden (1997) her "intuition that caring is ethically important". And that "caring expresses ethically significant ways in which we matter to each other, transforming interpersonal relatedness into something beyond ontological necessity or brute survival" (p. 1). I concur with Benner and Wrubel (1989) who also believe that caring sets up what matters to a person thus providing a differentiated world in which there are meaningful distinctions that provide motivation and direction, and provides the positive freedom to choose and act (pp. 1-2). Of course the freedom to choose and act does not come alone, it is paired with the requirement to take responsibility for those choices and actions. In order to stop further erosion of the valuing of caring, I agree with Watson (1990b), that "approaches to knowledge that preserve human caring as the interface between technologic and bio-behavioural sciences, and ecosystems need urgent research" (p. 21). Most importantly, I believe that caring as "the act of reaching out to someone who is 'other', with the intention of meeting that other's need for their own sake, and in full recognition of their uniqueness and intrinsic value as a human being, is one of the highest forms of humanity. It is a truly healing and a deeply ethical act" (Cleary, 1999, P.166).

It is what occurs in the true partnership relation, that experienced, expert nursing practice continually strives for, despite increasing time and institutional pressures. Given the ethical nature of caring practices (Fry, 1989, 1990; Watson, 1990a, 1990b; Benner, 1991, 1994; Gastmans, 1998, 1999), it makes sense that caring should be involved in our ethical deliberations and decision making. As Watson (1990b) states, "We need windows and doors that embrace the humanity and the relational life processes of patients, nurses and ecology…" (p.23). In order to take a more authoritative position and establish a basis for

future work, a comprehensive exploration of the literature concerning caring, bioethics and the state of relations between the two was undertaken.

Background

With this understanding and a measure of frustration and puzzlement at the lack of valuing and understanding of this that I encountered within the healthcare system, vertically as a nurse and horizontally as a patient, I embarked on the MA Applied (Nursing) to extend my knowledge and give me the opportunity to teach nursing as a way of remaining sane and in nursing despite some level of disability.

Within the MA (Applied) program in the Graduate School of Nursing and Midwifery at Victoria University of Wellington, I took two papers NURS 521 Health Policy and an Ethic of Care, and NURS 531 Nursing, Midwifery, and Health Services in Aotearoa/New Zealand that had a watershed effect on my thinking regarding caring and ethics within nursing. These papers underpinned and developed not only my understanding of the challenges to caring in healthcare but the importance of the legal and most particularly the ethical aspects of caring. In the first paper NURS 521, I developed a connection with the ethic of care and a broad understanding of the critique and discussion surrounding its establishment and acceptance within feminist theory, nursing theory and bioethics. Importantly, the political aspects of the position of caring and an ethic of care were brilliantly brought out into the light by the paper coordinator Joy Bickley with the relevant astute information and observations she shared with us, not to mention the well chosen speakers from the wider community invited to present to us on this subject and related issues.

In this paper I found theories, ideas and information that joined with my own thinking and began to give me some ideas and tools to express my deeply held

concern for what I perceived as a increasing lack of valuing and erosion of caring within the healthcare system. The latter paper required the preparation of a paper for presentation at a relevant conference entitled " Care, politics, and an ethic of care"(now published in the Journal of Law and Medicine) and submitting it for presentation at the conference. I was astonished but elated when my paper was accepted. I went to Melbourne and presented it at The Australian Institute of Health, Law, and Ethics conference on "The Costs of Health". This paper expressed my concerns about the effects of the increasing undervaluing and erosion of care on people's health in the context of the radical economic changes in the healthcare system. The paper also outlined the importance of caring, its ethical aspects, and some possible reasons for their increasingly low value status and position, in particular the political and moral boundaries.

It was not my presentation so much but the actual attending of this multidisciplinary conference that was a significant galvanising step in the development of ideas leading towards this thesis. As the conference proceeded, it became evident that amongst the other disciplines of bioethics, medicine, and law, there was a glaring, although not quite total, lack of consideration of caring as an ethical or valuable factor in health. This seemed especially so when reducing costs was an issue. In further discussions with conference attendees I was struck by the other disciplines' representatives apparent lack of knowledge of the wealth of theory, research and scholarly writing that has been developed within the discipline of nursing and feminist theory (and even other bioethicists and philosophers and noted scientists) regarding caring, its importance, ethical aspects, in relation to health. To me it seemed they were all thinking and writing (and making decisions, policies, and laws) with only "part of the story" completely either ignorant or dismissive of an entire relevant body of experience, research and theory. I was informed by a bioethicist that as the only nurse, my presentation had been novel, interesting, enjoyable even, but I had ruined my credibility by citing work by Carol Gilligan. He said hadn't I known

"that Gilligan was marginalized in mainstream bioethics and no longer considered of any significance (personal communication, Dr Daniel Sullivan, October, 1998). A discussion ensued from which Dr Sullivan eventually departed, but not before admitting that different approaches to ethical situations could be helpful and an ethic of care could be reconsidered (Personal communication, Dr Daniel Sullivan, October, 1998).

My thinking turned to what the possibilities might be if there was more dialogue and information sharing across disciplines particularly in regard to the ethical nature of caring and its relationship to people's health. This remains my long-term goal, to work and write in the interdisciplinary area concerning ethics and caring. However, more immediately important was a need to learn more, a desire to know and understand to increase my knowledge about bioethics and what place caring could or should have within it.

Methodology

This was a personal journey of exploration and immersion in literature, taken to expand my understanding and knowledge of the nature of caring and its place in bioethics. Selected sources of literature from the disciplines of, nursing, feminist theory, bioethics and other relevant related areas were utilized in this journey taken by the author in the form of an extensive literature review. The online databases CINHAL and Bioethics Line were accessed through OCLC First Search and OVID and used to search for relevant peer reviewed articles between 1975 and 2001. Articles and books unobtainable from the Victoria University of Wellington library were sourced through their interloan service or from the medical library of the University of Otago School of Medicine (Wellington), and the Law Library of Victoria University of Wellington. Books and articles were also sourced from the Massey University, Wellington, library, and the New Zealand Nurses Organisation library. The Publication Manual of the American Psychological Association was used for referencing and citations

and grammar, and every care has been taken with the referencing and citations to eliminate any mistakes and potential plagiarism. It is to be understood that the choices of literature, decisions and overall perspective brought to bear in the development and resulting finished thesis are overall, from and influenced by, my social and cultural background, my life experiences both personal and professional. The worth and validity of this work rests on its level of coherence, and its making sense and fitting or resonating with the reader's perspective.

Organisation of the thesis

To present the thesis in a consistent coherent manner that best displays the process and aim of the study to explore the place of caring in bioethics it has been organised into seven chapters. The first two chapters are concerned with introducing the subject of caring, and providing evidence of its place and position in society from a broad then a narrower focus.

Chapter Two: Relation, health and reality: A wide-angle view of the fundamental importance of caring to human being.

This chapter presents a discussion of the issues and implications surrounding the difficulties of defining caring. Evidence in support of the importance of caring to human life is presented from a broad societal perspective, and the chapter concludes with an indication of the predicament of the paradoxical position occupied in society by caring.

Chapter Three: Caring: Positives and negatives through the feminist and nursing lenses.

This chapter presents a narrower focus on the positive and negative aspects of caring from the feminist perspective and the nursing perspective. Both disciplines have considerable bodies of research and scholarship regarding what is seen as positive and negative about caring from each perspective. This

is drawn from in order to present a greater depth and detail regarding not only caring, but also the ethical aspects of caring and its development as an ethic of care. Finally the similarities and differences of the two perspectives are discussed with possible implications for interdisciplinary dialogue.

The next two chapters introduce bioethics as a subject and identify the main characteristics, important terminology and an historical perspective of the influences pertaining to its evolution. This perspective is aimed at presenting a clear picture of bioethics in its current form. To provide finer detail and depth, positives and negatives are discussed through a critique of contemporary bioethics from the bioethical, nursing and feminist perspectives.

Chapter Four: Bioethics: An orientation to the present, from a telescopic view of the past.

This chapter deals with the issues of clarifying confusing terminology and fluid boundaries in bioethics as a fast growing and developing discipline. As bioethics was formed in part from philosophical ethics, the past and continuing influences of this genealogy are presented in order to indicate that connections between past and present have been, and still are, significant in shaping bioethics.

Chapter Five: Contemporary bioethics: A critical portrait from the bioethical, nursing and feminist perspectives.

This chapter presents an outline of the significant features of contemporary bioethics, the closer connection to law, the increasing multidisciplinarity and the effects of plurality and the postmodern perspective. In order to provide more depth and detail of both positive and negative aspects, as with caring, critique of ethical decision making, focusing largely on clinical practice, is presented from the bioethical, nursing, and feminist perspectives.

The next chapter diverges from the previous pattern and takes from the previous four, what stand out as the most significant predicaments, or difficulties involved in caring having a place in bioethics, and explores some possibilities for their solution or management.

Chapter six: Possibilities for a place for caring in bioethics: Adding some new lenses.

This chapter examines two significant predicaments in finding a place for caring as an ethic of care in bioethics, the care/justice duality, and the problem of the conceptualisation of autonomy. Evidence is presented supporting different ways of approaching these two predicaments, that possibly may contribute towards their resolution.

Chapter Seven: Discussion and reflection.

This chapter concludes the thesis with a final discussion of the conclusions and limitations of the study, followed by an outline of the implications of the study and its relevance to nursing. Finally, a reflection on the process of the study, and directions for the future are presented.

Terminology

In this study I make no distinction between the terms ethical and moral. The term ethics is often seen as representing formal universalisable theory and the term morality as representing more informal private personal ideas and values. In fact, according to (Ladd, as cited in Johnstone, 1994) there is no philosophically significant difference between these terms and they can be used interchangeably and according to personal preference.

In this study I use the term patient rather than client. While I don't feel satisfied with either term I have, on balance, decided on the former.

Summary

The purpose of this initial chapter is to introduce the reader to the topic of the thesis of an exploration, the place of caring in bioethics, and provide an orientation to this study. It outlines the focus of the study, how it came about, how it was carried out and how it has been organised for presentation to the reader

CHAPTER TWO

RELATION, HEALTH AND REALITY: A WIDE ANGLE VIEW OF THE
FUNDAMENTAL IMPORTANCE OF CARING TO HUMAN BEING.

" The essence of what it means to be human is not to be found in the individual human

being but in the personal relationship which exists between two human beings."

(Feuerbach, as cited in Buber, 1970)

Introduction

This chapter is the first of two exploring the nature and importance of caring. Both this chapter and the following chapter are concerned with providing the reader with background evidence on caring with which to proceed to the later chapters that explore more directly the issues regarding caring and its relationship with bioethics. The purpose of this first chapter is to present from a broad societal perspective, the complex and critically important nature of caring within the reality of everyday human existence. This includes examining the difficulties and desirability of defining caring, exploring and elaborating the fundamental importance of caring to human health and relationships, and ultimately human survival. It also attempts to illuminate the paradoxical position that caring occupies in society, and the mechanisms that maintain this paradox where the importance and ethicality of caring is obscured and devalued.

The complexity of defining caring

Before attending to the nature of caring in relation and in health, it is necessary to look at the problems of defining caring. This needs to be dealt with first because how ideas about caring are formed is a fundamental issue that affects the reality of not only how caring is seen, but indeed whether caring is seen.

The issue of defining caring has significance throughout this thesis, not least in the specifics of the relationship between caring and bioethics.

The multiple manifestations of caring

Caring is a broad, complex, multifaceted, ubiquitous and essential phenomenon that is deeply embedded in virtually every aspect of human daily life. Every culture has its own word(s) or action(s) that represent caring. However despite this, caring can still be recognised throughout the world, if not by verbal expression, then at least by its non-verbal and sometimes even more eloquently expressive body language (Ekman as cited in Darwall, 1998, p.265). Leininger (1981), a nurse theorist, has concluded from her studies in the area she describes as transcultural caring, that caring is "an essential human need for the full development, health maintenance, and survival of human beings in all world cultures" (p.3). Tronto (1993), a feminist political theorist, also agrees that caring is multifaceted, global, and both culturally and biologically essential. She states that

> *…despite the fact that the meaning of care varies from one society to another, and from one group to another, care is nonetheless a universal aspect of human life. All humans need to be cared for, though the degree of care that others must provide depends not only on culturally constructed differences, but also on the biological differences that human infants are not capable of looking after themselves, and that sick, infirm and dead humans need to be taken care of (p. 110).*

In this sense, from its everyday necessity and occurrence across cultures, caring can be seen as a concept that has to some extent a universal aspect. However, Tronto (1993) further explains that despite all human beings' need to be cared for "…care is not universal with regard to any *specific* (my emphasis) needs"

(p.110). In agreement with this, Bowden (1997) states, "What goes as caring and what is understood as its ethical significance are by no means indisputable in any *particular* case" (my emphasis) (p. 1). Therefore, although there may be universally recognised aspects to caring, in any particular instance, caring is expressed in a unique manner that is directly related to the situational context in which it is occurring. Thus, caring can be seen to have both particular and universal aspects. As a result caring can and does take on a rich diversity of forms, in a vast range consisting of both concrete and intangible, verbal and non-verbal features, that can in turn be arranged in a multitude of combinations (Bowden, 1997; Carse, 1998; Darwall, 1998; Little, 1998; Tronto, 1993).

Although one of the most common approaches that people take to begin to understand something is to look for a succinct definition that applies always and everywhere, given the nature of caring as outlined above, such a definition seems unlikely. The multifaceted contextual diversity of caring, including both universal and particular aspects, despite the logical presence of some commonalities and near commonalities, bestows upon caring a fundamental unpredictability that defies capture in one concrete definition.

The unpredictability and uncertainty concerning caring, and its resistance to definition, do not fit well with proponents of the scientific and positivistic perspectives, and others who insist on precise measurement and categorising for material, economic, or knowledge development purposes. These perspectives are not without value but they are based on the long-standing, and pervasive notions of certainty and predictability where there is the existence of one ultimate truth that will explain all (Capra, 1985). It must be pointed out that this is one way of seeing but not the only way. Capra points out that other perspectives or paradigms exist that are also of value and can contribute much to human life. However he also points out, that although the scientific positivist perspective is no longer quite as dominant as it has been in the past, in many

areas and on many levels it still provides the criteria for what is accepted as knowledge and therefore what is deemed valuable.

Caring is not by any means the only such phenomenon to be unpredictable and resist definition so strongly. Of particular interest, given the nature of the traditional scientific perspective, the predicament of attempting to define caring concretely, has a most striking parallel found deep in the heart of science itself. Similarly unsuccessful attempts have been made within the discipline of physics to concretely define subatomic particles. In the esoteric realm of particle physics, scientific experiments set up to measure and define subatomic particles have demonstrated repeatedly that the subatomic particles, that is the electrons, protons, and neutrons in the nuclei of atoms (literally the basic matter of the universe) do not exist as single concrete objects as expected. According to Capra (1985) "Depending on how we look at them, the electrons, protons and neutrons appear sometimes as particles sometimes as waves" and further, that this variable nature "…is also exhibited by light, which can take the form of electromagnetic waves or particles (photons)" (p.67).

In much the same way as with caring, the moment you choose to focus on a subatomic particle to measure and define it, it becomes something else and the particle changes form. Thus it is impossible to absolutely define the particle as you only ever see one part or aspect of the whole of what the particle (or caring) can be at any one time (Capra, 1985; Prigogine & Stengers, 1987). What has been demonstrated in these experiments is that the specific properties a subatomic particle displays at any particular time, has been repeatedly shown to be dependent on its environment. Also, the perspective and approach that is brought to the particular observation by the person attempting the measurement has been established as directly influential on the outcome (Capra, 1985; Khun, 1999; Prigogine & Stengers, 1987). In short it introduces

uncertainty and choice into a science based previously on certainty and unequivocation. According to Prigogine and Stengers (1987)

> *All description thus implies a choice of the measurement device and a choice of the question asked. In this sense, the answer, the result of the measurement does not give us access to a given reality. We have to decide which measurement we are going to perform and which question our experiments will ask the system. (p.224)*

Ultimately, the implication for physics is that this undoes the classical notion of objectivity and, at the same time, removes certainty, as has been formally substantiated by the "Heisenberg's uncertainty relations", a formula that mathematically describes the phenomenon of uncertainty as discovered in Quantum theory (Prigogine & Stengers, 1987, p.225). Rephrased with regards to caring, the above quotation would read as – All description of caring thus implies a choice of the definition employed and perspective applied. In this sense, the answer, the result of the chosen definition does not give us access to a given reality. We have to decide which definition we are going to use, and which perspective that in our attempts to define caring, will be brought to bear on the caring situation. It can be seen that attempting to define caring closely fits with attempts to define this quantum phenomenon. According to Prigogine & Stengers (1987)

> *…there are various possible individual points of view on subatomic particles (or caring) from a viewer's perspective, but they all deal with the same basic universal reality - subatomic particles the matter of the entire universe - (the universal aspects of caring), but it is impossible to reduce them to one single definition. (p.224).*

In summary, to borrow further from Prigogine and Stengers (1987), caring exists as "an irreducible multiplicity of representations" (p.225), and should not and indeed cannot, be truthfully represented in a single concrete definition. This has important implications for how we approach the development of an understanding of caring, in that ultimately we are responsible in terms of our choices, and ethics for our perspective of caring. This will be pursued further on in this chapter.

If it is accepted that a concrete definition of caring is not possible, except presumably under the constraints of individual, specific and non-transferable parameters, how does one go about formulating a deeper understanding and knowledge of such a complex phenomenon as caring? It is precisely because caring can be so many things to so many people, that the question 'what is caring?' according to Kitson (1993)

> *…is a question of concept, in that to understand the word 'care' the individual must engage in looking critically at what care means to him, to people around him, how it is described in literature, the media, defined by scholars, and so on. A definition of caring is not what is needed, but rather a divergent exploration of how ordinary people use the word (p. 28).*

Thus, rather than pursue a single concrete definition, each person needs to embark on their own journey and formulate their own conceptual understanding of caring. As Kitson further explains

> *Concepts have both a logical and psychological dimension to them. They parallel the meaning or definition of certain words, but derive their special use from being able to map out and explain what meaning individuals attach to certain things (1993, P.29).*

However, this does not necessarily mean the creation of multiple incommensurate individual understandings of caring. The process of an individual forming a concept of caring is unique to the individual, but within that process we draw from a pool of common experiences by virtue of being human and also by belonging to groups and cultures. Thus the individual concepts will have a range of greater and lesser degrees of commonalities among them. The common human, biological, and cultural aspects of lives in some cases, provides similar but not identical experiences and contexts that imbue individual conceptions with commonalities. These in turn provide links that according to Kitson (1993), we can then use to create a shared or common understanding of the issue in question.

Caring is not the only term better understood using a conceptual approach as opposed to concrete definition. My point in emphasising this here is that, as opposed to simply accepting a definition formulated by someone in a dictionary or elsewhere, in the process of concept formulation the individual's attention is harnessed and focused intently and critically on the object or phenomenon in order to reach an understanding and form a concept of it. This is significant because caring is so deeply embedded in people's lives that much of it passes by us unnoticed and that which is unnoticed is taken for granted (Greenleaf, 1991, p.74). Therefore this engagement and attention focused on caring is much needed and most welcome, and there is the hope that it may take the person beyond their everyday superficial assumptions and ideas regarding caring. This is explained well by Kitson (1993) where she says that, "Using and talking about concepts has the effect of making us self conscious about words that we have *hitherto used without thinking* (my emphasis)" (p.27). She further elaborates that, "we become more conscious and look critically at our actions, *reflecting on both the action and the significance of that action.*"(my emphasis). Finally, Kitson (1993) emphasises that in sharing our concepts once

formulated they can contribute to an even deeper and broader understanding of the phenomenon. This approach appears to be particularly fitting in the case of developing any depth of understanding of caring, or other phenomena that exist as irreducible multiple representations.

At this point for the sake of clarity, as a beginning understanding, and in order to have something to hang our developing conceptual ideas on, it is necessary to provide a very basic, broad, but workable description of caring. According to Tronto (1993), "On the most general level care connotes some kind of engagement" and she further explains that it carries with it two additional aspects "first, care implies a reaching out to something "other" than self …Second, care implicitly suggests that it will lead to some type of action" (p. 102). I would add to that description by including that the action implicit in care would be intended to be beneficial, and that it can be extended to the "self" as well as someone or some thing "other". Human beings have the ability to be self aware as Fromm (1975) points out, "Man… has awareness of himself, of his fellow man, of his past, and of his possibilities for the future." (p.14). Staying at the very broad descriptive level, caring can also be viewed as a "species activity that includes everything we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible" (Fisher &Tronto as cited in Tronto, 1993, p.103). Tronto herself adds "that world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life sustaining web" (1993).

No single description can be held as representative of all that caring can be, at best, we capture only one facet of the whole, or at worst a distorted perspective of its nature and form. According to Dunlop (1994), if caring "could be captured by rules, it would not be caring." (p. 38), and she uses the example of language to elaborate on her statement by saying that

If, for example, we consider language, we can see that our culture provides us with a vocabulary of words and patterns for their use, but to simply use set words and follow set patterns is, in an important sense, not to really speak the language. Similarly, our society can be seen as providing us with examples of caring, but to simply copy these is to lay oneself open to the charge that one does not really care. (Dunlop, 1994, p. 38).

It still remains that a means of forming a useful and workable understanding of caring in its complexity needs to be found. Bowden (1997) has developed a way of apprehending the complexities of caring, involving the examples of caring provided by society, not by copying them but by using them in a very specific manner. Bowden has based studies of ethical caring practices in her book *Caring: Gender sensitive ethics* on the examination of multiple examples of caring practices. Her aim was to show that the complex "plurality of possibilities expressed by different forms of caring in different persons' lives" (p.11) could be captured, made visible and understood without resorting to reductionist methods. Bowden employs the idea that her investigation is not directed towards phenomena but "towards the 'possibilities' of phenomena" (Wittgenstein as cited in Bowden, 1997, P.2). This idea comes from aspects of the second major work of philosopher Ludwig Wittgenstein (1889-1951) titled "Philosophical Investigations" published in 1953 two years after his death. This second work of Wittgenstein was notorious for being the complete and utter antithesis of his first ardently positivistic and most influential work the "Tractatus Logico-Philosophicus published earlier in 1921. Bowden works with the Wittgensteinian notion from the second work, Philosophical Investigations, that understanding a concept is a practical capacity involving "knowing how to go on using it - of knowing the salience of the uses given in the explanatory examples - when other examples are encountered."(Wittgenstein as discussed in Bowden, 1997, p. 13). That is, as Bowden explains, a concept is best understood by giving examples of particular ways the concept is used, not by

defining its boundaries or by giving a complete reductive analysis of its function.

According to Bowden (1997) when faced with the interpretation of multiple possibilities (as in the case of caring) it is possible to see that conceptual explanation is a matter of assembling particular exemplars that direct interest in a particular way (p.13). From Wittgenstein's perspective, clarity of understanding or 'perspecuity' as he describes it, "is produced by a discerning juxtaposition of different 'objects of comparison' that enables appropriate connections to be made among them." (Wittgenstein as cited in Bowden, 1997, p. 13). Bowden interprets this as meaning that "a survey of different examples can guide understanding by pointing to patterns of similarities and dissimilarities among them that bring a certain dimension into focus"(pp.13-14). Further surveys can then be done that draw attention to other dimensions, and therefore understanding. In this case of her investigation of caring practices, understanding comes from multiple surveys of examples of the caring practices. According to Wittgenstein, as cited in Bowden (1997), developing this form of understanding does not entail "limitless manipulations of examples", the assembling of examples is not infinite but is constrained by the range of particular purposes the assembler shares with those persons she/he is engaged in communicating with (p.15).

This provides something of a caveat, however, as a survey of 'objects of comparison' according to Wittgenstein as cited in Bowden (1997), "can only produce understanding when it brings to light patterns or connections that reveal dimensions of meaning hitherto hidden or dormant in the practices of those who would understand "(p.15). Thus Bowden interprets in relation to her work that " a survey of different relations of care can only produce understanding of caring if it illuminates aspects of caring that already lie implicit within the range of those seeking understanding" (p.15). This

interpretation is very important and has deeper significance for the relationship between caring and bioethics to be discussed further in chapter three. With these parameters understood, Bowden carried out her enquiry "by surveying the possibilities and limitations of four examples of caring relations: mothering, friendship, nursing and citizenship" (p.15). Each chapter takes one of the caring practices, drawing attention to the particularity of its contextual setting and the specific kinds of relational concerns that the setting brings to bear on the form of caring expressed. Within each chapter Bowden (1997) juxtaposes different writers' perspectives on the practices under consideration, thereby following a process that repeats the survey method and connects the separate chapters This allows the development of a comprehensive understanding of caring under the guidance of learning what is salient in each context.

In summary, Bowden's method of apprehending the complexity of caring is through investigating the caring practices of mothering, friendship, nursing, and citizenship. The investigation is based on an idea from Ludwig Wittgenstein of developing an understanding of complex phenomena by, in this case, examining multiple examples of caring practices. This is done by collecting and presenting a range of examples of each practice set in its own particular context that are then juxtaposed and compared from different perspectives (writers). The process involves moving back and forth among the examples noting similarities and dissimilarities. In this way, understanding of the complex phenomena of caring is gained without using reductive processes that destroy the integrity of the wholeness of caring.

The invisibility of caring practices

Bowden's use of comparing examples of caring provides a possible pathway to understanding the multiple manifestations of caring in a manner that is more able to reflect and preserve its complexities and wholeness. However, there is another barrier besides the difficulty of defining or understanding and

developing knowledge about caring. It is that caring and care work is largely invisible (Tronto, 1993). This barrier has the ability to undermine the usefulness of Bowden's approach and any others developed. The reason is that, at the most fundamental level caring must first be seen, it must gain people's attention, be recognised as valuable and worthy of attention in order for efforts towards understanding and investigation to be stimulated. Unfortunately in much the same way as people are largely unaware of breathing as they go about daily living, (unless it is somehow impaired), so too the myriad daily caring acts pass largely unnoticed by our conscious awareness. Bowden (1997) points out that we often miss as Wittgenstein has observed, "the aspects of things that are most important for us… because of their simplicity and familiarity"(P.5). She further explains this feature of caring in the following manner

The very common and everyday nature of our involvement in caring relations- from the deep intimacies of family relations to the innumerable, publicly exchanged gestures and words of personal significance that craft institutions and communities- produces an aura of invisibility. (Bowden, 1997, p.5-6).

This "aura of invisibility "serves to obscure caring from the focus of our attention. This invisibility of caring, together with the inability to adequately define caring (for those who insist on definition or measurement in order to be acceptable), and the considerable effort and resources required to develop other ways of understanding caring, constitutes a formidable double barrier. This barrier effectively prevents the recognising and acknowledging of the real importance and value of caring within the many aspects of human life. Quite simply you cannot come to know or value what you do not see or recognise. Greenleaf (1991) provides a clear example of this in her discussion of how caring is influenced by its social context, firstly by the expectation that caring acts will occur within that context, and secondly by the resources brought to support such caring acts. She gives the following example

If, for instance, we establish an AIDS hospice to provide a humane place for people with AIDS who are dying, the intention is for caring acts to occur there. In fact, the expectation is so strong, so unequivocal, that it seems to be stating the obvious to even mention it. The notion of caring acts is so deeply embedded in the meaning, the intent of hospice, that it usually remains unstated. The taking for granted of such caring acts, this notion that they are inherent in certain social contexts renders the acts themselves, and the people who perform them invisible (Greenleaf, 1991, P. 72).

A flow on effect from this is that unseen invisible caring acts cannot be recognised as important or valuable and therefore do not register as requiring any resources to support them. The results of this are as Greenleaf continues to explain

If the social context establishes an intent for caring acts to occur but fails to provide the necessary resources to sustain them, caring will fail in spite of the most heroic efforts of individuals to sustain it alone. It is easy to imagine how individuals may then be held responsible for the failure of caring even when the breakdown is in the supportive system or context. The potential for, and some would say actual, scapegoating of women – who perform most of the caring acts – for system failure is great. (1991, P.72-73).

This demonstrates not only consequences of the invisibility of caring, but also the critical integral nature of the relationship between caring and the context in which it occurs which is a fundamental characteristic feature of caring, as Greenleaf (1991) also explains

> *Failure to recognise the relation between caring acts and their social context keeps hidden from view the civilising contributions of caring. It keeps hidden the power that caring has for altering not just the reality for individuals within the caring act itself… but also to alter the meaning of the context, and the world beyond it by making them more humane (p.73)*

Another very important area of human life where the contributions of caring and caring work are invisible, and their power and potential for influencing change is also hidden is in economics. Tronto (1993) points out that "care consumes a large part of our daily lives although we do not pay systematic attention to this dimension of life" (p. 111). If caring consumes a large part of our daily life it would seem logical and appropriate that it would be significant in economic terms. Although the perceived increase in financial costs of caring for health problems in healthcare systems has been a significant focus (Kelsey, 1997) most of the everyday caring and caring relations, according to Waring (1988), that work to produce sustain and maintain individuals' and communities growth, development, health and quality of life are not significant in economic terms. More insidious than this, there is evidence that caring is actually excluded from local, national and international accounting systems that are used to inform economic and social policy development, and resource allocation (Waring, 1988). In her book *Counting for Nothing*,

Waring demystifies economic accounting systems, clearly explains and exposes unequivocally how the particular selectivity of the United Nations System of National Accounts (UNSNA), excludes and makes economically invisible women's unpaid caring and labour. She also exposes that this system of economic accounting lacks any imputed value for the environment. According to Waring (1988), the UNSNA is a system of economic measurement used globally by the World Bank, the International Monetary fund, and the United Nations (UN) agencies, and has been adopted and used by many national

governments (including New Zealand). She further explains that the selectively gathered information from this system is used to determine aid, funding and resource needs, to project markets, plan investments and develop policy, globally, nationally (including social policy) and ultimately filtering down to local communities. The UNSNA is only interested in cash generating activities, and not productive capacities. Thus at all levels an enormous amount of unpaid productive and reproductive caring, and caring work is rendered invisible and valueless by this system. As Waring states

> *The current state of the world is the result of a system that attributes little or no "value" to peace. It pays no heed to the preservation of natural resources, or to the labour of the majority of its inhabitants or the unpaid work of the reproduction of human life itself – as well as its maintenance and care. **The system cannot respond to values it refuses to recognise**. (1988, p. 3).*

She provides the following examples. Firstly people who stay at home and rear children are considered unemployed and therefore unproductive and they and their work are excluded from the system of economic accounting. Yet few would deny, and certainly anyone who is a parent knows well, the very real work, long hours, financial costs, and physical intellectual and emotional effort required to rear children. Waring (1988) quotes an American Senator Daniel Moynihan as saying " 'If American society recognised home-making and child rearing as productive work to be included in the national economic accounts, the receipt of welfare might not imply dependency. But we don't' " (p.6). Secondly Waring states that,

> *Many of the environmental resources we value are excluded from measure in the economy. They cannot be sold in private markets, so it is said to be difficult to determine what they are worth. Yet their destruction, and the costs of cleaning up after the destruction, are labelled "growth" and "production (1988, p.26).*

Thus, as Waring elaborates, the costs of cleaning up pollution appear in the national accounts, the benefits of a clean environment do not appear. Chopping down trees and rainforest are included, but a living tree or forest providing oxygen and habitats for living creatures does not. They are deemed unproductive and have no value according to the UNSNA. When presented so clearly, as Waring does, it seems improbable that the perversity of the situation is not immediately clear to everyone and that something is not being done to change the situation. Waring (1988) points out that this situation persists, as does the use of the UNSNA that leads to the situation. It does indeed seem as the philosopher Wittgenstein has stated, we tend to be blind to "the aspects of things that are most important for us" (Wittgenstein as cited in Bowden, 1997, p.5).

The caring and caring work that is rendered so invisible and economically valueless is carried out within a network of relations, that are in turn frequently rendered invisible and of little value. However, the perspective informing the UNSNA is one perspective, albeit a very powerful and pervasive one. There are others. The feminist and nursing perspectives on caring and relation are two important views that will be explored in some depth in the following chapter three. More immediately, and continuing at the broader level the significance of the intimate involvement and interaction of caring, relation, and health in the reality of daily human life, will be explored. The relationship between them is poorly understood, although few people if directly asked, would deny their importance.

Caring in relation and health

Biological, and anthropological, aspects

Roach (1987) holds that caring relations are essential to human growth, development, and health. However, caring goes a step beyond that. It is fundamental not just to our health and relationships, but indeed to our very survival as a species (Watson, 1990b). "Quite simply, people die when it is absent or inadequate" (Cleary, 1999, p. 386). A very stark reminder of this is provided by Ashley Montagu in his book *Touch: The human significance of the skin* published in 1978. He cites statistics from studies carried out in some orphanages in the USA in the early 1900s to discover the cause of marasmus, a mysterious "disease" of infants who waste away and die. Montagu explains that as late as the second decade of the twentieth century the death rate for infants under one year of age in various foundling institutions throughout the United States was nearly one hundred percent (p. 77). Montague also reports

> *…that it was in 1915 that Dr Henry Dwight Chapin, the distinguished New York paediatrician, in a report on children's institutions in ten different cities made the staggering disclosure that in all but one institution every infant under two years of age died (P.77).*

Resident babies, although having their basic needs mechanically met for food shelter and cleanliness, simply failed to thrive and died. Montague (1978) further explains that Dr Chapin recognized the "emotional aridity" of children's institutions and organised a system of boarding out babies with families. In these cases the infant survival rate showed some increase. However, it was a Dr Talbot who spent time in a children's clinic in Dusseldorf, Germany before World War One that brought back with him the practice of "tender loving care". At that clinic he discovered they had an older servant woman who would carry the sick babies around with her, talking to them and caressing them. The Director of the clinic told Dr Talbot that "when we have done everything we

can medically for a baby and it is still not doing well, we turn it over to old Anna and she is always successful" (p.78). Simply it seems, because she gave the babies tender loving care. In context it must be remembered that at that time doctors and parents alike were under the thrall of the Dr Spock equivalent of the time, a booklet titled *The care and feeding of children* first published in 1894 and latest edition in 1935. The author, Luther Holt, Professor of Paediatrics at New York Polyclinic and Columbia University, "recommended the abolition of the cradle, not picking the baby up when it cried, feeding it by the clock, and not spoiling it with too much handling." (p.78). Tender loving care was at the time considered "unscientific"(p.78) and its practice was discouraged, most successfully among the middle and upper classes.

This stark but powerful example demonstrates all too clearly that without caring human babies simply die. It was initially thought at the time that marasmus was due to inadequate nutrition, but even with adequate nutrition mechanical performance of the necessities and cleanliness are not enough. For survival we need caring or more precisely the establishment of caring relationships. For something so fundamentally important how is it then, that care, care work and those who largely perform this work in our society are so devalued and compartmentalised? Even more significantly in considering this example the questions are raised; what status and value do our relationships have in human life? What status and value does caring really have within those relations? What status should it have? And if caring is so fundamentally important to survival let alone merely " living the good life" should it not be considered of ethical importance, and have a role in ethical decision making?

The disciplines of anthropology and archaeology have clearly established that relation and particularly caring relationships are primary. Historically human beings have always been, as they remain today, a gregarious social species. They are rarely found as isolated individuals living completely without any contact with others (true hermits). They prefer, even if actually living alone as a

single person, to be in connection and have a sense of belonging through relation with others rather than to be in isolation (Feuerbach as cited in Inwood, 1995; Ridley, 1996; Salzberg, 1997). According to Fromm (1975),

Being separate means being cut off, without any capacity to use my human powers. Hence to be separate means to be helpless, unable to grasp the world- things and people- actively; it means that the world can invade me without my ability to react (and further that) the deepest need of Man, then, is to overcome his separateness…Man– of all ages and cultures- is confronted with one and the same question; the question of how to overcome separateness, how to achieve union, how to transcend one's own individual life and find at-onement (p.15-16).

Consequently human beings gather in groups developing and maintaining a range of cultures that display the many different interpretations of how life can be lived (Geertz, 1986). All of these individuals and groups of people- as cultures, and as different groups within the many cultures- are born, brought together, maintained, constrained, transformed, dissolved and reconstituted by the infinite permutations of the relations, that exist between them. According to Ridley (1996), "We are far more dependent on other members of our species than any other ape or monkey" (p.6). We cannot live with out each other the 'I' needs a 'you' " (Feuerbach as cited in Inwood, 1995, p. 277), and not least for the reproduction and survival of the human species.

Psychological, and philosophical aspects
Caring and relation are not only instrumentally essential for protection and survival of the species there are deeper, complex qualitative aspects to human relations. The development of mutual, caring relationships are the basic threads from which qualitatively unique human lives and histories are woven. This idea

is expressed by the philosopher Martin Buber in this manner, "Man's creativity is the energy which is given to him to form and direct, and the real product of this creativity is not a novel or a work of art but a life lived in relation" (Buber as cited in Friedman, 1976, P. 65-66).

There is an enormous range of different kinds of relation that are necessary to accommodate the adequate and effective communication and functioning within the equally large and deep complexities of human life. It is not merely necessary that relation exist in and of itself, but also that the quality or nature of the relation allows for virtually infinite, flexible, adaptable levels of subtlety and nuance required for the healthy development and flourishing of human beings. This is of course also necessary for the relatively smooth functioning of complex cultures and society in general. This in turn supports the more qualitative aspects of life such as the achievement of life goals, pleasure and satisfaction of complex aesthetic needs in the connections and communications between humans and between humans and other living creatures and the environment. To a certain extent, quality of life is related to quality of relations, which has great significance psychologically for human beings.

Relation between human beings is a dynamic, open social process that does not occur in a vacuum. It is always set within a context from which it is continually susceptible to multiple influences from many directions and levels, some of which are within our control and some which are not (Geertz, 1986; Miller, 1976). Amongst other things, the dynamic nature and susceptibility of relation to contextual influences (as is caring) means that a relationship can take many forms ranging from the ultimate altruistic expression of acceptance, love, and nurturing support, to distrust, exploitation, and the destruction of self and/or other(s) (Tronto, 1993; Carse, 1996; Miller, 1977). Given a favourable context that provides adequate resources and support for skilful, life enhancing caring, as previously discussed by Greenleaf (1991), the presence of caring can provide

the communication, cohesion, and relative stability that determines a high quality of relation. When caring is either inadequate or absent in relation, then relation is stripped to its bare instrumental bones, and as Montagu (1978) has previously pointed out survival is unlikely. Even survival of older children and adults is questionable as Fromm (1975) explained previously, people who are separate, not in relation, and who do not have a sense of belonging experience psychologically intolerable levels of fear and anxiety. The biological aspects of caring are only one part, human beings have an enormous psychological capacity and need for caring. Bowden (1997) captures these aspects of caring as she states "caring expresses ethically significant ways in which we matter to each other, transforming interpersonal relatedness into something beyond ontological necessity or brute survival" (p. 1).

When caring is present in its supported skilful and life enhancing forms, caring can be thought of as the interstitial fluid of relation. When working well, caring's achievements are truly supererogatory, with an adaptive flexibility it gives definition in the sense of shape and form, supports, makes room for growth and development, provides some cushioning effect between the relation and the external world, and provides some means of repair. It creates stability for smooth functioning, while allowing for a carefully filtered flow of new material to nurture the relation at the same time as allowing for some removal of unnecessary or harmful material. In summary it could be stated that human beings flourish in relation sustained by caring described as reaching out to an "other" in recognition of a need, with the intention of meeting that need in a manner that is consistent with the wishes of the one cared for and recognises the unique wholeness, dignity, individuality, and historic situatedness of that person (Cleary, 1999, P. 385).

Historically, caring and relation have not received a lot of attention in philosophy. There are several reasons for this that will be studied in the

following chapter. However there are several noted philosophers and thinkers from the traditional era of philosophy who have found caring a worthy subject for study, and managed to make an impact with their thinking. Of these, two of the most influential have been Martin Heidegger, and Martin Buber. Buber was a Jewish religious thinker born in Vienna in 1878. His works have become accessible to the English-speaking world through translations and interpretations of the translations. According to Geering (1983) for Buber

…everything that is, exists in relation. It is out of relation, in the fullness of time, that life emerged. Life reaches its most complex and highest level in human relationships, and, whenever those relationships are threatened, all that we most value, including life itself, is under the threat of extinction. (pp.13-14).

Before anything else in human life there is relation, from the moment of conception before sentience there is relation, through the connection with the mother, and even before that, the act that brings about conception is, in its ideal form, indeed one of deep intimate relation (Geering, 1983, p.17). "…without it a human being cannot live" (Buber as cited in Berry, 1985, p.x), and further, for Buber the most fundamental characteristic of our life as human beings is the "innateness of the longing for relation"(Buber as cited in Berry, 1985, p.42). As Berry explains from Buber's perspective

In the sphere of the human… there is no person, no situation, contact, or involvement with another human being that is excluded from the possibility of being a partner in dialogue – from the most fleeting and occasional, to the most stable and enduring (1985, p.42).

Buber's relation or "being a partner in dialogue" is not all encompassing. He insists that on entering into relation there is the necessity to let the other be without being reduced or subsumed or absorbed. Rather one life opens up to another life, without incorporating the other (Berry, 1985). In the detailed explanations that Buber gives regarding the forms of relation, caring, which seems more implicit in much of his writing, is made explicit particularly in his book "I-Thou" where he explains according to Geering (1983) that "the 'I thou' relationship is reciprocal… there is a mutual response. There is an encounter, the one with the other and the other with the one, a genuine meeting."(p.16). This leads to an important point that is characteristic of a life enhancing caring relationship and imparts in some degree an indication of its ethicality. From Buber as cited by Berry (1985)

Every true existential relationship between two persons begins with acceptance. By acceptance I mean being able to tell or rather not to tell, but only to make it felt to the other person, that I accept him as he is. 'I take you as you are' (p.*)

In a different existential approach Martin Heidegger (1962) is a philosopher who addresses caring explicitly from an ontological perspective in his existential phenomenological philosophy outlined in his seminal work "Being and time". According to Heidegger as cited in Roach, "man's essential relation to the world is one of care. 'To be is to care,' and the various ways of 'being-in-the-world' are different ways of caring" (P.4). Roach (1987) further explains, for Heidegger

Care is the basic constitutive phenomenon of human existence. It is thus ontological in that it constitutes man as man. All existentials used to describe Dasein's self have their central locus in care. When we do not care, we lose our being and care is the way back to being. Care is primordial, the source of action and is not reducible to specific actions (p. 4).

From his book "Being and Time" "Heidegger developed hermeneutical phenomenology as a Philosophical methodology to uncover the meaning of being of human beings, the significance of which he claimed had been covered over by past philosophical approaches that were reductionistic and objectifying" (Plager, 1994). As a research methodology Heidegger's hermeneutical phenomenology provides "a theoretical basis for conducting research projects that does not reduce issues of human beings' concerns to mere characteristics, absolute properties, or brute data" (Taylor as cited in Plager, 1994). There is an interesting connection to note between Wittgenstein and Heidegger in the matter of embedded familiarity leading to blindness. Heidegger claimed "that we are so culturally and socially embedded in familiarity with our practices and skills that we lose sight of our being from existing within this familiarity" (Heidegger as cited in Plager, 1994, p.66). While Wittgenstein claimed that we often miss "the aspects of things that are most important to us… because of their simplicity and familiarity" (Wittgenstein as cited in Bowden, 1997, p.12). Both of these philosophers appear to have a deep understanding of both the difficulties and the importance of capturing the elusive, contextually embedded meanings of human life. The methodologies developed from their philosophies, have been successfully used by Plager (1994), Bowden (1997), and others see for example Benner (1984, 1994,) to capture and make caring more visible.

It seems that there is some strong support philosophically and psychologically for the fundamental place and importance of caring in human life. However it also seems that despite some support, those who largely perform the caring and the caring work in the present society, continue to be devalued and compartmentalised (Tronto, 1993; Bowden, 1997).

The paradoxical position of caring in society

Given the evidence presented so far in this chapter indicating the fundamental importance of caring and caring relationships to quality of life, sustaining health, and providing the means of our very survival, it seems that caring should be much higher in our values. This poses the question of what status and value should caring hold in human life and society? Why is caring not more visible, and being recognised for its complexity and useful abilities in areas beyond the presently accepted private realm. Why is there not better funding and resources for research and development into caring practices, along with instrumental support? Should caring not have considerable political presence and status? But above all given its centrality to the quality of human life if not its very survival should it not have a place in bioethical and ethical deliberations and decision making? The reasons why caring is in the position it is at present and the possibilities of its ethical aspects will be the subject of the next chapter.

Summary

This chapter has been concerned with presenting information and evidence at a broad level regarding the nature of caring and the importance of caring in human life. It has considered the nature of caring and the difficulties and inadvisability of attempting to pin it to one concrete definition as the way of understanding a complex phenomenon such as caring. It has also looked at some of the consequences for caring in not being reducible to concrete definition and how that can influence how and indeed whether caring is seen and made visible. It has pointed out that in trying to define complex phenomena there are surprising connections between caring and hard science, and that the new developments of a science of complexity may bring more connections and better understanding of both human science including caring, and the natural sciences. It has looked at ways of developing an understanding of caring in its complexity without resorting to reductive processes through the

presentation of the investigation of caring practices carried out by Peta Bowden using a Wittgensteinian approach of a comparative analysis of examples of the practices embedded in their particular contexts, comparing and juxtaposing them to see their similarities and dissimilarities, repeating the surveys to build a comprehensive understanding.

Finally it has looked at the biological, anthropological, psychological and philosophical connections of caring and relation and their connection to health, quality of life and most importantly human survival. It concludes by posing the question, given the fundamental importance of caring why is it so devalued, and given that it is necessary beyond merely living the good life why does it not feature more prominently in our ethical deliberations and decision making processes. The next chapter will explore these questions at a more specifically focused level from the feminist and nursing perspectives, as these two groups have a significant concern and considerable experience in the investigation and research of caring and its relevance in human life.

CHAPTER THREE

CARING: POSITIVES AND NEGATIVES THROUGH THE FEMINIST AND NURSING LENSES

To gain a depth of understanding about a subject it is necessary to view it from different perspectives

Introduction

This chapter follows on from chapter two in maintaining caring as the subject, but alters the focus from a broad societal perspective to viewing caring from the feminist and nursing perspectives. Both the disciplines of nursing and feminist theory have significant interests and concerns regarding the phenomenon of caring. This is due in part to their close association with the nature and impact of caring practices in their life experiences as women and as nurses, who are still predominantly female (Condon, 1992; Bowden, 1997). As a result of these interests and concerns, nursing and feminist theory have developed considerable bodies of work, rich in depth and detail, of past, present, and ongoing investigations into caring. Part of these investigations has been a strong focus directed toward the ethical aspects of caring including the subsequent development of an ethic of care and its possibilities. Drawing from the work of both feminist theory and nursing, this chapter will attempt to address the questions posed in Chapter Two and support that chapter's broad focus with a more specific depth of focus on the importance of caring and its ethical aspects. The two perspectives, although having points of connection, are quite different, and this chapter will also explore some of the similarities and differences.

The feminist perspective of caring and an ethic of care

The feminist perspective

The feminist perspective of caring, or indeed of any topic, is not one unified perspective. It is a plurality of views that involve different schools of feminist thought; for example, liberal, radical, psychoanalytical, socialist, and ecofeminist, as well as different individual views. Tong (1993) makes a further distinction within the feminist perspective between feminine and feminist views. She holds that the feminine view regards the gender traits traditionally associated with women, in particular nurturance, compassion, and caring as positive human traits. This view perceives that these traits are undervalued in society and seeks to have them valued and celebrated. On the other hand according to Tong the feminist view is specifically political and sees women as suppressed, repressed and oppressed. It seeks to eliminate this subordination by arguing against patriarchal domination for equal rights, and fair distribution of scarce resources. Feminists in general also acknowledge the interconnectedness of the issues of race class sexuality, disability, and age with those of gender ascription (Tronto, 1993; Bowden, 1997). They also acknowledge the tension between individual and community needs, and seek to include all voices and not to deny the unique experience of the individual, while at the same time understanding that there are community and cultural voices as well with commonalities and differences.

Given such a broad range of views the feminist perspective is not without its critics from both within feminist theory itself and from outside it. Some have criticised the plurality of views in the feminist perspective as indicating an inability to reach some form of consensus or finalise a position, particularly in the case of caring (Veatch, 1998). However, Browning-Cole and Coultrap-McQuin (1992) have the more positive view that it can be seen as healthy discussion and debate allowing a greater range of perspectives and possibilities to be brought out for consideration in a field of rapidly evolving theories and

approaches. In part, I believe, the varied range of approaches and debates may also be seen as indicative of an openness to exploration and change in feminist theory, a willingness to look within as well as without, a state not encountered so vigorously in all disciplines. Kheel (1993) an ecofeminist writer emphasises that if we are sincere in the desire to live in a world of peace and non-violence for all living beings, "we must help each other through the painstaking process of piecing together the fragmented world view that we have inherited" (1993, p. 261).

Despite the diversity in the feminist perspective, however, there is also unity, as according to Little (1996), all feminist theorists, scholars, and thinkers share several fundamental characteristics. Their work always displays

> *…an attempt to uncover the ways in which conceptions of gender distort people's view of the world and to articulate the ways in which these distortions, which are hurtful to all, are particularly constraining to women. (p. 2)*

These works are not merely "benign protestations of women's value or equality", Little explains, because the assumptions about gender have shaped not only the ways in which we think about men and women, but also "the contours of certain fundamental concepts-from motherhood to rationality-that constitute the working tools of theoretical analyses" (p. 2). Even though, or perhaps because of, the assumptions at issue are often so subtle or so familiar as to be invisible, the "distorted and harmful conceptions of gender have come to affect the very ways in which we frame our vision of the world, affecting what we notice, what we value, and how we conceptualise what does come to attention" (Little, 1996, p.2). The focus of feminist perspectives and their reflections on such things as gender distortions in society, have contributed many new insights that can create possibilities for change by "altering what

questions people think to ask, what topics they regard as important, what strikes them as a puzzle in need of resolution." (Little, 1996, P.2).

Another of the fundamental characteristics common to feminist theory is the view that human society, "to put it broadly, tends to be androcentric, or male-centered." (Little, 1996, p.3). Although there are changes afoot in this area it still largely remains that "man is treated as the tacit standard for human… the unstated point of reference, for what is paradigmatic of or normal for humans" (Little, 1996, p. 3). What this means, as Little further explains, is that certain features of men-their experiences, their bodies, their values-have subconsciously come to be regarded as constituting the human norm, and she provides an example from psychology of how this androcentric view has tended to define the *human* mind.

> *In a famous study (Broverman et al. 1970), when psychologists were canvassed and asked to describe the "healthy" man, the "healthy" woman, and the "healthy" human, the list for men and humans turned out to be virtually identical, the list for women divergent (Little, 1996, p.4).*

The conflation of male with the general terms human and normal is made quite clear here. Certainly there have been changes between then and now, but as Tronto (1993), and Little (1996), point out, the changes are neither comprehensive, nor uniform in depth. For example, the use of only male participants in drug trials for drugs that are also prescribed for women, when it is highly possible there could be significant differences in uptake and tolerance levels (McCarrick, 1995). This possibility has already been scientifically established in the case of alcohol tolerance.

Given the feminist perspectives focus on uncovering gender distortions in society that negatively affect everyone, a considerable amount of attention has

been focused on caring, due to the nature and significance of its impact in the lives and experiences of women. The relationship between women and caring and how they are both valued and positioned in society is complex. To some extent based on the thinking "that one cannot change what one does not understand" (Kheel, 1993, p. 244), feminists from all walks of life and professional backgrounds have made a concerted effort to investigate caring thoroughly. They ask questions about both the positive and the negative impact of caring practices on the lives of women, children, men, the environment and the structures and social organisation that do, or do not, support the caring practices.

The feminist perspective of caring.

One of these feminist investigations, gives an answer to the question from the end of chapter two regarding the paradox of how caring can be at the same time so vital to human life and yet be so undervalued and compartmentalised. This investigation provides an insight into how the position of care in society is maintained by a matrix of both subtle and complex, value and social structures. Studies by Tronto, (1993) present an analysis of care as work, that reveals a perspective on how these structures and values help to set a higher value on the kinds of caring done by the more powerful, while those who are less powerful are left with the less important caring.

It is essential here to emphasise the point that both research and statistics support the fact that gender, is not the only significant factor in determining who does caring work. According to James and Saville-Smith (1994) the issues of gender race and class are so entwined in our cultures that they are virtually inseparable, and to consider one in any depth is to eventually encounter the other two. Tronto (1993) confirms this as she agrees that "in fact not just gender, but race and class, distinguish who cares and in what ways in our culture." (p.148). Further to this she explains that

If we look at questions of race, class, and, gender, we notice that those who are least well off in society are disproportionately those who do the work of caring, and that the best off members of society often use their positions of superiority to pass caring work off to others (Tronto, 1993, p. 149).

To illustrate this Tronto sees that caring occurs as a four-phase process:

1. *Caring about - recognising that there is a need*

2. *Taking care of - recognising that something can be done to meet that need*

3. *Care giving - the direct meeting of needs hands on*

4. *Care receiving - the acceptance and response to the care delivered.*

According to Tronto (1993), 'Caring about' and 'Taking-care-of' are related to broader public issues, associated more with public roles, and are seen as duties of the more powerful. 'Care giving' and 'Care receiving' are related to more private issues and private roles and are seen as duties of the less powerful.

Tronto continues by elaborating that traditionally the least well off in society are women, servants and slaves that have always included people (men and women) of colour. The caring for children, the elderly people, and the sick or disabled people, especially when concerned with direct bodily contact, has largely been done by women. Cleaning and low skilled maintenance has largely fallen to people of colour, and the poor. According to Tronto (1993) this is clearly demonstrated in the USA where mostly Black and Hispanic men and women take on a relatively greater percentage of this work, along with less well off white men and women. The division of caring labour is, however, not as simple as this. Tronto argues that there are more subtleties in the division of

caring labour that blur the unfairness, and decrease the likelihood of reaction and action, that would occur if it was more blatantly obvious.

In regard to such subtleties there are several powerful myths that stem from these value and social structures that Tronto has identified. Firstly, prevalent in many Western liberal societies is a pervasive myth regarding an individual's state of autonomy based on the idea that "…we exist as independent, autonomous individuals when closer examination, as in the discussion of relation in chapter two, shows that in reality, we exist in complex webs of relation sustained by care" (Cleary, 1999, p.166). The reality is the majority of our daily decisions are not made in true autonomous fashion without any accounting for the presence, wishes, or needs of others, and cultural and societal rules. As discussed in Chapter Two humans live in relation, which necessitates certain levels of communication and compromise between individuals for the smooth functioning and survival of those relations, which are in turn necessary for our survival as a species.

Secondly, there is a myth that our society is based on true equality when it is actually based on the assumptions bound to the idea of equality of opportunity. According to Tronto (1993) under this assumption glaring inequalities can be tolerated in society because it is understood that the responsibility for success and flourishing (and health) lies with the individual, and other influential factors are ignored. For example, a successful individual is seen as successful because she/he has taken up an opportunity available, whereas the unsuccessful individual is seen as unsuccessful because she/he has not taken up the available opportunity. Under this myth the construction and organisation of social structures, our values, environmental factors and the state, are seen to have no responsibility or part to play in influencing the ability of the individual to access the opportunity. The success or lack of success of the

individual is entirely attributed to her/him. This is especially so in liberal democratic societies. The third myth is

> *that our society is suffused with the idea that individuals are seen in a dichotomous way, as either autonomous and independent, or dependent and needy. Again the reality is that we all without exception, continually move through varying states of need and of dependence and interdependence from birth to death simply by virtue of the process of human development if not by some incident with illness or injury as well (Cleary, 1999, p.166).*

The opposition set up by this dichotomous view is not helpful in illuminating the real needs of people and serves to hide the importance of relationships and especially caring relationships. Both the feminine and feminist perspectives agree that we need each other to care and be cared for, but the ramifications of the potential extent of this need are so threatening to some, that it necessitates separating the need out, denigrating its importance, and compartmentalising it (Tronto, 1993; Miller, 1976).

The work of Jean Baker Miller, a psychologist noted for her work with women in the 1970's, (see her book "Toward a New Psychology of Women", published in 1976) provides some explanation for the fear and threat perceived in caring by many men and also provides an alternative to the negative view of the weakness and vulnerability assumed to be inherent in women's natures. Although Miller's work may seem dated, it is worthy of discussing here because she deals with some very basic issues that underpin caring, still not often dealt with openly and thus remaining pertinent.

According to Miller (1976) society is built on an exceedingly restricted conception of the total human potential, holding up narrow and ultimately

destructive goals for the dominant group (largely males) and it attempts to deny vast areas of life (p. 47). Some of the denied areas she discusses are sexual and intimate caring relations, dependence, vulnerability, and emotion. She further explains that some of these aspects are such necessary parts of human experience that "they cannot be 'projected' very far away. One must *have* them nearby, even if one can still deny *owning* them." (Miller, 1976, p.47). To 'deny owning them' means not admitting to having the need for them. Miller then concludes that, "the falsity and full impact of this limited conception has been obscured"(p. 47).

Probing more deeply into the integral psychological and emotional aspects of caring particularly concerning feelings of vulnerability and weakness Miller (1976) explains that "…the issues of how a person is made to feel vulnerable or helpless and what she/he then tries to do about it is probably the basic issue underlying most modern concerns in psychiatry" (p.37). To care about something or someone immediately makes us vulnerable, it is often admitting to a need a wish or desire, and more importantly there is the fact that in many cases we simply cannot guarantee or control that the response required will be forth coming. The key point Miller makes is that, vulnerability and weakness, long associated with being female and generally abhorred and denied by males, is a natural part of human life. According to Miller (1976),

> *In no society does the person -- male or female -- emerge fully grown. A necessary part of all experience is a recognition of one's weaknesses and limitations. That most valuable of human qualities -- the ability to grow psychologically -- is necessarily an ongoing process, involving repeated feelings of vulnerability all through life (p. 31).*

Miller explains that men have been conditioned to fear and hate weakness, and to try to get rid of it immediately which she believes represents an effort to distort human experience, when in fact,

It is necessary to "learn" in an emotional sense that these feelings are not shameful or abhorrent but ones from which the individual can move on -- if the feelings are experienced for what they are. Only then can a person hope to find appropriate paths to new strengths (p. 31).

In Miller's view women are better able than men to consciously admit to feelings of weakness or vulnerability and we have not recognised the importance of this ability. She goes on to say that life in general, and particularly in our society, generates these feelings in everybody, but women are truly much more able to tolerate these feelings because both superficially and deeply, they are more closely and touch with basic life experiences and in touch with reality. Miller states that "by being in this closer connection with this central human condition, by having to defend less and deny less, women are in a position to understand weakness more readily and to work productively *with* it" (p. 32), and therefore use it as a positive strength. Ultimately her point is that women can become the developers of a different understanding of weakness and vulnerability and of the appropriate paths out of it rather than be carriers of it (Miller, 1976, p.32).

However, she adds that "... if the members of the dominant group-that is, men-claim that they do not have feelings of insecurity, subordinates (women) cannot challenge the claim"(p.33-34). Furthermore, it is women's responsibility to then supply the needs of the dominant group so that its members can continue to deny these feelings. Unfortunately the fact that such emotions are present in everyone, and are intensified by the problems that our society creates for all people, makes this difficult situation most difficult to resolve (Miller, 1976).

There is another significant human life task to which caring is fundamental that is also undervalued and compartmentalised namely participating in the development of others. The benefits of the caring integral to this process, however, are often overshadowed by the unfair distribution of this task within society overwhelmingly to women (Miller, 1976; Held, 1995; Carse & Nelson 1996; Bowden, 1997). According to Miller (1976) and Tronto (1993) there is no question that the dominant society has decided that men will do the important work, and women will tend to the lesser caring work of helping other human beings to develop. As Miller states "…this dichotomy means that our major societal institutions are not founded on the tenet of helping others to develop. All people need help in development at all stages, but it is made to appear as if only children do" (1976, p.40). This provides yet another distortion and Miller explains that this causes difficulty for both women and children, particularly with psychological consequences for children of both sexes.

However, on the positive side, women generally have a much greater understanding of the pleasures of close connection with physical, emotional and mental growth than men (Miller, 1976). This is undeniably changing in the world with the advent of paid parental leave for both men and women becoming standard in many Western developed countries, (although not New Zealand as yet). This is making it easier for both parents to spend time with infants and many men are simply choosing to take more active parenting roles even choosing to be the main caregiver while the woman continues with employment. What has not changed is that "women have had to do this major work without the supports that a culture would give to a task it valued" (Miller, 1976, p. 40). Finally, Miller makes the point that such close involvement with growth and development results in developing intimate knowledge of participating in change. Thus in a positive way women can become more at ease and adaptable to change, and as she notes the adaptability to change also unleashes the accompanying skills of creativity and cooperation (Miller, 1976).

Some negative aspects of caring

There is no doubt that as essential to life as caring is, it has significant negative aspects and forms. From the feminist perspective, many of the negative aspects of caring have deep historical roots and associations. These begin with the position and valuing of women in general in society, where from ancient Greek times and throughout history even to the present day, woman has been regarded as a deficient human. In Aristotle's view, woman's place in his hierarchy was only just above slaves both male and female, and she played no part in the world outside the home (Groenhout, 1998, p. 172). Many influential male thinkers such as Kant, Rousseau, and Thomas Aquinas, quite apart from Aristotle and continuing through the centuries of time not only held, but also taught their intractable views "that women were rationally and morally inferior to men, and therefore incapable of theoretical reasoning, or shaping a system of morality" (Kant as cited in Johnstone, 1994). The powerful positions and influence these men had in the thinking and philosophy of their times has been overwhelming and far reaching lingering right through into the attitudes of the present.

As a result of this history, the feminist perspective holds that " social institutions and practices have encouraged discrimination against women" (Browning-Cole & Coultrap-McQuin, 1992, p 1). Further to this they see "that which is tightly and consistently associated with women tends to become devalued" (Little, 1996, p. 10) As caring has been and is so associated with women, caring has been and is devalued, while at the same time, in a vicious circle, women's association with caring and care work that is devalued, in turn devalues the women (Tronto, 1993). Thus in some feminist perspectives, caring is seen negatively as a way that women are kept oppressed by the dominant patriarchy in order to serve their needs. As Ruddick (1995), points out many caring relationships in a patriarchal society are often not a result of women's free choice but are heavily socially sanctioned expectations. According to

Bowden (1997), in the view of some feminist theorists, "women's caring is seen as a coerced practice on which their survival depends" (p.8), and she further points out that

> *These critics note the typical lack of reciprocity in women's practices of care, the limited set of relations in which caring is normally expected, and the ways in which practices of care may undermine integrity and ethical agency. …and, in fact, perpetuates the reign of the dominant by encouraging self sacrifice and servility in the guise of care (Bowden, 1997, P.8).*

Other negative aspects of caring from the feminist perspective concern how "caring comes to be perceived as an innate characteristic of women and therefore a natural determinant of women's social possibilities and roles" (Bowden, 1997, p.8). Held (1990) explains that this connection is plainly seen when associations traditionally built up are examined

> *…the public realm is seen as the distinctively human realm in which man transcends his animal nature, while the private realm of the household is seen as the natural region in which women merely reproduce the species… Dominant patterns of thought have seen women primarily as mothers, and mothering as the performance of a primarily biological function… Women accordingly have been thought to be closer to nature than men, to be enmeshed in a biological function involving processes more like those in which other animals are involved, than like the rational discussion of the citizen of the polis…" (p.334-335).*

Where the association of caring with women has been seen as natural, that is, as an essential, inherent part of being a woman, Bowden (1997) points out that, "correlatively, the absence of caring attributes is used to castigate and denigrate

women" (p.9). Ultimately the essentialist association of women and caring in the manner described above results in the enormous diversity of women's caring practices "tending to become ossified in abstracted and prejudiced models of femininity and care" (Bowden, 1997, p.9).

The consequent compartmentalisation of stereotypical women and caring relationships to within the boundaries of the private realm of domestic personal and intimate relations is a further negative aspect, according to Baier (1995) Bowden (1997), Groenhout (1998a), and Held (1995). This limits the range of practices of caring, reinforces the traditional splitting of public and private realms and between men's and women's caring possibilities. The outcome of this segregation is, as Miller explained previously, a necessarily narrow and distorted construction of humanity brought about because in this public/private segregation each half of humanity is deprived of the benefits of a total broader experience, and a more balanced view of what is possible for humanity (Carse, 1991; Little, 1996; Miller, 1976).

The feminist literature containing discussions and debates on the negative aspects of caring is considerable, and this is wholly to their credit as they boldly tackle aspects of human life and society where others have either feared or been too uninterested to go. As Bowden (1997) points out

> …the tendency to see the perspectives and concerns arising from maternal and other practices of caring simply in a positive light glosses over the dark side of these practices: the frustrating demeaning and isolating dimensions of their routines. 'Care' has a lengthy history in the (English-speaking) West as a burden. A bed of trouble, anxiety, suffering and pain (p.9).

Thus within the feminist perspectives on caring there is a tension between the feminist approach who see the need for radical political changes for women position to improve and the feminine approach who tend to concentrate more on raising awareness and support for valuing traits commonly associated with

women. From a feminist perspective it is vitally important to understand and face up to the negative aspects and forms of caring in our society but that does not mean that caring should be dishonoured or abandoned (Carse, 1991; Carse & Nelson, 1996). The value placed in care by those supporting the feminine approach is not misguided especially given the evidence of the fundamental importance of caring to the survival and quality of human life as discussed in Chapter Two. However, there is a definite need to find ways to reduce and avoid the traps and negative formulations of caring, or in some cases it is the removal of barriers and boundaries distorting caring practices that is required (Tronto, 1993; Bowden 1997). Means to support and facilitate good caring, caring that is done well, need to be found and developed.

Noddings (1984), and Gilligan (1982) building on the work of Miller (1976) and Chodorow (1974) have taken up this challenge by exploring the ethical possibilities of caring as a potential source for positive examples caring "done well". As Noddings explains, to do caring well the natural inclinations present in human beings need to be built on. Both Noddings, and Gilligan along with Held (1990), and other feminist theorists eschew any essential or natural basis to women's traditional association with the tasks of caring. They believe this association to be socially constructed rather than something that is innate. They further maintain that understanding and development of good practices of caring can, and in their view preferably should be, learned by all human beings (Chodorow, 1974; Held, 1990, 1993). It is these authors' investigations through both feminine and feminist perspectives of caring that have brought about the understanding that caring has ethical importance as an integral part of human life, and particularly to ethical development, as well as supporting the ability to actually be ethical. This in turn brought about the development of feminist ethics and the development of an ethic of care.

Feminist perspective of an ethic of care

It is the work of Carol Gilligan, most well known for her book *In a Different Voice* first published in 1982, and the work of Nel Noddings, most well known for her book *Caring: A feminine approach to ethics* published in 1984, that have been credited with establishing grounds for the importance of the ethical aspects of caring. This has subsequently grown into a field of inquiry into the ethical nature and possibilities of caring.

Carol Gilligan established that there was a different moral voice to be heard, when she challenged the validity of Kohlberg's six-stage moral development theory that was based on a traditional ethical theory of justice. She condemned it as inherently biased because Kohlberg, an internationally renowned moral development theorist, had used all male samples as the empirical basis for his theory construction. Gilligan pointed out that in using only male samples the theory could hardly be taken as representative of human experience. Gilligan also challenged Kohlberg on the basis of her own research into the apparent differences between male and female moral reasoning. She found that many women had a different approach to ethical situations. Rather than use an objective abstract principled view, they tended to want more information about the concrete aspects of the situation, and they focused on the care and responsibility of relationships between people in the situation.

Gilligan (1982) sees that many women come from a world of relationships and psychological truths, where an awareness of the connections between people gives rise to the recognition of responsibility for one another. She also sees that while many women have taken care of men, men have, in their theories of psychological development, as in their economic arrangement, tended to assume or devalue that care. Of the latter, I believe Marilyn Waring's book *Counting for Nothing* provides an excellent account. They see concern with relationships as a dependency and as a weakness of women, rather than as a

healthy interdependency and a human strength, as discussed previously by Miller (1976).

According to Gilligan the different voice she discovered in her research appeared predominantly to come from women. However, she was roundly criticised for placing too much emphasis on the attribution of this different voice to women only. Many of her critics seem to have overlooked that in her book she clearly made the point that

> *…it is primarily through women's voices that I trace its development. But this association is not absolute, and the contrasts between male and female voices are presented here to highlight a distinction between two modes of thought and to focus a problem of interpretation rather than to present a generalisation about either sex…no claims are made about the origins of the differences described or their distribution in a wider population, across cultures, or through time. Clearly, these differences arise in a social context where factors of social status and power combine with reproductive biology to shape the experience of males and females and the relations between the sexes (Gilligan, 1982, p.2).*

Further research cited in Tronto's book "Moral Boundaries: A political argument for an ethic of care" published in 1993, substantiates that the different moral voice is found also among people of colour, amongst some tribal societies, and people who are poor. Therefore, like the issue of the relationship between gender, race, class, caring, caring work, the different moral voice is not just about gender. However this does not render Carol Gilligan's work invalid as some critics have maintained. Marilyn Friedman points out

> *… the different voice hypothesis has a significance for ethical theory and ethics which would survive the demise of the gender difference hypothesis. At least part*

of its significance lies in revealing some of the obsessions that have distorted theories of morality… until recently (1993, p.121).

Noddings (1984) provides another approach for an ethic of care. She claims that it is not only different from, but is ultimately better than, an ethic of justice that has favoured theoretical reasoning over practical modes of reasoning. In doing so, Noddings claims that the ethic of justice has neglected the kinds of personal intimate relationships that sustain the lives of all human beings. She holds that most of us have memories of caring and tenderness from our very first relationship with our mothers, and this leads us to a vision of what is good—a state that is good in itself—and to a commitment to enhance that good. Noddings (1984) believes that ethics begins at the emotional level with the desire to be a good person, rather than at the intellectual level with the analysis of the concept of goodness. This notion is supported by Blum (as cited in Tong, 1993) who states that "altruistic emotions such as sympathy, compassion, human concern, and friendship are necessary components of morality" (p.74), and further to this "that the motive of the action can not be separated from the action" (P.75). Noddings insists that ethics is about particular relations and uses the model of a two person relationship made up of 'the one caring', and 'the one cared for' to explain her ideas.

Feminist scholars and philosophers have established a feminist ethics within which many have contributed to the development of an ethic of care in response to the perception that traditional ethics did not adequately reflect the moral experience of many women or answer their moral questions (Fieldman, 1987). In general the main disagreements of those who espouse either a feminine or feminist ethics, with those who espouse traditional ethics according to Johnstone (1994), are that

1. Traditional ethics is too abstract to be useful in practical everyday affairs.

2. It focuses too intensely on abstract rules and principles, rather than promoting quality relationships between people.

3. It has tended to privilege the interests of white middle class, able bodied, heterosexual males, at the expense of those deemed other and hence inferior; for example, women, people of non-English-speaking and culturally diverse backgrounds, disabled people and so on (p.103).

Johnstone (1994) also questions the value neutral account of rationality, and why reason should be regarded as having more authority in moral thinking than the moral sentiments of empathy compassion, sympathy, kindness, and caring.

Regardless of the form an ethic of care takes the predominant feminist perspective is that it is not held up as a replacement for all of traditional ethics. Rather it is to address the lack of inclusivity of different views, and a need for a greater ability to be responsive. An ethic of care does not present itself as a universal theory, this would collapse it back into the form of traditional ethics, and deny the aspects crucial to the new perspective, namely the richness in the difference of individual ways of caring, and the different cultural meanings, ways, and values of caring. It is a plurality of approaches that according to Johnstone (1994) is more congruent with the view of transcultural ethics and the ethics developing from an ecofeminist view, both of which can enhance our ability to actually be moral, in a world of diverse and competing valid world-views. An ethic of care is still a 'work in progress', however, its main themes can be summarised into a useful description as an approach to ethics that-

Recognises the main moral concern is with needs and corresponding responsibilities, and a caring commitment to respond

Recognises the inseparability of persons and their environments and that choice is contextually bound and dependent on the particularities of the situation

Values and supports the connections and relations between the people involved

Values and supports the natural interdependent relatedness of human beings (Cleary, 1999).

Given the focus on caring, responsibility, and relation it would seem self-evident that these ethical aspects of caring would logically also have relevance for nursing as a discipline much concerned with these elements. Therefore, in the interests of providing comprehensive coverage, the remaining half of this chapter is devoted to presenting a nursing perspective of the positives and negatives of caring and an ethic of care, and finishes with a discussion of the similarities and differences between the feminist, and nursing perspectives.

A nursing perspective of caring and an ethic of care

The nursing perspective

Like the feminist perspective, the nursing perspective is a plurality of views that are wide ranging and also sometimes conflicting. However, the nursing perspective has its own unique and specific origins arising from the fact that nursing is a practice based professional discipline. Nursing as a profession was developed in response to social requirements for the provision of a proscribed and particular form of health care practice. As such, it rests on a social contract, as do other professions, based initially on the notion set out by Donabedian which according to the New Zealand Nurses Organisation, Social Policy Statement (1993) claims that "there is a social contract between society and its professions in which trust by the public, and self-responsibility on the part of the professions play a large part."(p.9). The nature of the contract and of the proscription of the form of health care practice provided by nurses, has been influenced by factors both internal and external to the profession of nursing throughout its developmental history, and continues to be shaped by these

forces. A comprehensive understanding of the nursing perspective does require knowledge and understanding of its history. However, as it is a matter of centuries, full coverage of this history is beyond the bounds of this study, and thus only a brief sketch as an orientation is provided here.

From early in human history, according to Reverby (1987), nursing evolved from woman's historical role in caring for the community's vulnerable individuals and was firstly imposed as a duty on women, then as the needs of society increased in times of warring and epidemics, it was then imposed as a duty on a paid nursing work force. According to Rafferty (1993) nursing work was seen as one of the few employment options, along with teaching, deemed appropriate for women in those early times and many women willingly took up this option for the relative amount of independence it gave them. This independence was certainly relative as Reverby (1987) points out that Florence Nightingale, considered as the originator of modern nursing, proved without doubt that nursing in and of itself made a difference to mortality in the battlefields of the Crimea, but then saw to it that nursing came under the "guidance" of medical doctors.

Nursing also adopted a hierarchical ranking as an organisational system that was closely aligned with the military model, along with associated behaviours and attitudes such as stern control of emotional involvement with patients. At this time, Rafferty (1993) explains, the emotional aspects of caring were kept well damped down as they were seen as detrimental to the nurse's ability to perform her duties. She further elaborates that caring in nursing, at this time, was seen more as a physical task oriented endeavour concerned mainly with the physical and bodily aspect of caring for the person and their immediate environment. These nursing tasks were carried out under the explicit direction of the physician and with total obedience (Rafferty, 1993). It is these historical roots and the subjugation of nursing under medical doctors that give feminists

pause. It makes them suspicious of nursing as a whole and of accepting ideas, theories, and caring practices upheld by nurses'. The feminist perspective sees that these caring practices and theories concerning caring have arisen directly from the profession of nursing that was developed as another version of patriarchal exploitation of women's caring practices (Bowden, 1997). This theme will be discussed further at the end of this chapter.

However, much has changed since that time. Nursing has grown, it began the journey of development into a discipline, and to find its own place to stand as distinct from being seen as an appendage to the medical discipline. Nursing theories emerged, along with the beginning of an abundance of research projects, the establishment of a domain of inquiry, the beginnings of forming a philosophy of nursing, and the establishment of its own nursing ethics. The changes to nursing have been considerable, particularly in deciding what the focus of nursing is, how to explain the nature and significance of what nurses do. What counted and what was involved in nursing knowledge was articulated in Barbara Carper's (1978) landmark article "Fundamental Patterns of Knowing in Nursing". She identified the scientific, aesthetic, personal and ethical ways of knowing in nursing. More recently White (1995) added the social way of knowing. Vigorous discussion and debate began concerning what methods, methodologies, epistemologies and ontologies are appropriate or inappropriate for the developing of that knowledge.

Nursing has moved from being task centred, with apprentice style learning on the job, to a theory based practice with an ethical basis taught in an academic setting at the tertiary education level. This involved the combination of a very broad academic programme involving physical and natural sciences, biology, microbiology, psychology, sociology, self-awareness, values clarification, cultural awareness and ethics, along with practical experience in a wide variety of workplaces. These changes have had enormous effects on nurses'

perspectives of themselves, the significance of their profession, their caring practices and the direction of their evolving discipline. The establishment of the importance of nursing research, and its consequent growth have played a large part in the changes.

In the development of nursing research, there was an initial concentration on positivistic scientific methods and methodologies, in the hope that it would bring acceptance, status and credibility with the medical profession and in the wider social world beyond. However, it was found that a single approach based on the scientific approach ultimately failed as Parker (1991) explains, it became clear that the scientific method based on reduction, abstraction, control, and prediction was not very successful in illuminating the kinds of projects of most interest and relevant concern to nursing. Even so the scientific approach has not been dispensed with entirely as according to Cox-Dzurec (1989) it is still very useful as long as its limitations are clearly understood, and it is considered as one among the many other approaches now included in developing nursing practice and knowledge. The debate in nursing research over whether there should be one or many approaches used to develop nursing knowledge, has been resolved with the acceptance of multiple approaches to fit with the plurality of perspectives (Cox-Dzurec, 1989).

The use of multiple approaches to practice and knowledge development means that different paradigmatic view points are present in nursing which in turn means that knowledge generated under the different paradigms will take different forms contributing to the plurality of the nursing perspective (Newman, Sime & Corcoran-Perry, 1991). As was pointed out by Guba (1990) in Chapter Two, the paradigms underpinning the approaches used, can be distinguished in studies and research by applying three questions regarding the ontology, epistemology, and methodology of the study. The ability to recognise and decipher the presence of different paradigmatic assumptions is almost an

essential skill to develop for assessing research and theoretical studies both within a discipline and in interdisciplinary situations. Further to this, with all the talk of plurality it is important that the nursing perspective is not misconstrued as meaning that its methods, research and enquiries are random or chaotic. The diversity of views and approaches within the nursing perspective, like the feminist perspective, has a unifying focus.

This unifying focus is "derived from a belief and value system about the profession's social commitment, nature of its service, and area of responsibility for knowledge development" (Newman, Sime & Corcoran-Perry, 1991, p.1). The concepts of person, environment, health, and nursing were identified by Fawcett (1984) as being fundamental to nursing. However, it is not just the concepts themselves that are important it is also the relationship between these concepts that is fundamental to nursing. Newman et al. (1991) developed Fawcett's concepts further by linking caring and health in nursing, quoting studies by Leininger (1984); Watson (1985); Newman (1986); Benner & Wrubel (1989); Benner (1984, 1994), that specifically link caring with health, healing, and well being (p.2). They also show that links are made between nursing, person and health, as Newman has stated that nursing "has something to do with how nurses facilitate the health of human beings"(p.3), and further that nurses are present with people as they are experiencing various states of health. Thus Newman, Sime & Corcoran-Perry (1991) concluded that a focus statement for nursing that relates these concepts to each other in a meaningful way, and identifies the domain of inquiry for nursing is that "nursing is the study of caring in the human health experience".

A further broad unifying focus comes from the fact that nursing practice is carried out within a relationship established between the person seeking help and the nurse. Bishop and Scudder (1990) point out this is not based simply on the nurse's desire "to be with that particular person but to help that particular

person become well… this relationship has an end beyond itself" (1990, p.152). This end, or purpose, as explained by Newman (1986), is to "facilitate the health of human beings" is the common end or purpose to all nursing relationships. Caring in the human health experience is always practised within a purposeful relationship, oriented towards the good of that person. However, the specifics of the caring relationship, its process, and outcomes, are unique to the particular characteristics and needs of the nurse and person involved, and their particular context. This is where the individual skilled caring practices of the nurses play their fundamental role. Ultimately no matter what the situation the nursing perspective is filtered through a flexible highly discerning caring lens that develops in expertise as experience increases.

A nursing perspective of caring

Within the discipline of nursing caring is held by most nurses as fundamental. Amongst nursing theorists it has been seen as the essence of nursing (Leininger, 1981), and as ontological, or a way of being in the world (Benner & Wrubel, 1989; Roach 1987; Watson 1985). Ontology is about how we perceive reality and it is absolutely fundamental (Guba, 1990). As a form of existence or way of being it is inherently holistic and informs all of who a person is and how they live their lives (Benner 1994; Benner & Wrubel 1989; Fry 1990; Heidegger 1962). In the reality of everyday nursing practice it is understandable that not all nurses reach the same depth of engagement with caring. As with other professions, there are a range of levels of expertise and competency, and nurses caring practices are no exception. Nurses' caring skills can vary for a number of different reasons that generally fall into two categories, those to do with the nurse personally, such as the amount of each nurse's experience, to individual personal, and professional reasons, and those to do with the broader context of nursing and health care, such as the political and institutional influences, particularly in regard to the degree to which they materially, and financially support and value caring and caring practices.

The professional discipline of nursing has in place standards for nursing practice, codes of ethics, continuing education programmes, post graduate educational opportunities, peer reviews, collegial support and ethical discussion groups, national associations and nursing regulatory bodies, professional performance assessments, crisis intervention teams, and individual and group supervision sessions. All of these work towards supporting the growth and development of nurses, and assisting those nurses who are experiencing difficulties, and/or who are seen to fall below accepted standards. It is the political and social climate, and employers' organisational ethos, that is more difficult to contend with. In that, they hold much power and they form the larger contexts in which nurses' caring practices are situated (Benner & Wrubel, 1989; Condon, 1992; Johnstone, 1999; Watson, 1990b). The political and institutional contexts have proven much harder for nurses to gain access to, and particularly at the levels where they can influence policy and decision making. Nurses in practice and nurses working in the academic, educational, and theoretical areas have been focusing their efforts on finding ways to support and value their caring practices, and to support and value the growth and development of their discipline.

Within the nursing perspective of caring there is a deep awareness of the undervaluing of nurses and their caring practices, and like the feminist perspective, they seek to find ways to make the value of what nurses actually do, and the caring skills involved in nursing practice more visible (Benner, 1984; Benner & Wrubel, 1989; Chinn, 1991; Watson, 1988, 1990). Part of the difficulty in accomplishing this satisfactorily is due to the difficulties explored in Chapter Two regarding the definition and articulation of caring without resorting to reduction and losing its complexity and holistic nature. However, part also stems from the fact that, caring in society in general, and caring within the healthcare system exist in a macrocosm—microcosm relationship (Bowden,

1997; Tronto, 1993). The undervalued status of caring and its compartmentalisation by the constraining social and value structures in the wider society, is mirrored in the undervaluing and compartmentalisation of caring within the healthcare system (Bowden 1997; Johnstone, 1999; Tronto, 1993). Benner and Wrubel (1989) wrote their book "The Primacy of Caring" in order to address "the cultural and ideological background that lies at the root of the… devaluation of nursing care and other caring practices". (p.xv). The book's aim was also to provide an alternative basis for legitimising and valuing the caring practices and making visible the expert knowledge embedded in nursing practice (Benner & Wrubel, 1989).

Rather than being completely concerned with prediction and control of variables, nurses seek approaches that are supported by philosophies whose epistemological and ontological perspectives are more compatible with, and more able to capture a nursing perspective of caring practices. These caring practices that are deeply involved with the understandings and meanings in the complexities of human lives and health experiences (Benner, 1984, 1994; Benner & Wrubel, 1989; Chinn, 1991). Theories of caring have been articulated (Swanson, 1991), and concepts of caring compared and analysed (Boykin & Schoenhofer, 1990; Morse, Bottorf, Neander & Solberg, 1991). However, in terms of making the actual, concrete caring practices in nursing visible, Benner in her book "From Novice to Expert: Excellence and power in clinical nursing practice" (1984) has been the most successful, though that success is still largely confined to within the discipline of nursing.

Benner (1984) employed a hermeneutic or interpretive phenomenological approach developed from the philosophies of Husserl, Heidegger, Gadamer, and Merleau Ponty. Heidegger (1962) in particular holds that caring is the most basic way of being in the world, as noted in Chapter Two, and his interpretive approach requires that

…to understand specific meaning of any behaviour (or nursing care measure), one must know the specific context , and knowing the context inherently limits the possible meanings of behaviour into manageable wholes. Therefore, the interpretive approach always relies on the particular context of the situation-that is, the timing, meanings, intentions of the particular situation (Benner, 1984, p.40)

Benner (1984) has used narrative accounts of what she terms "paradigm cases", that are exemplars from expert nurses' practice, to capture the 'timings, meanings and intentions of the particular situations'. Benner (1984) presented and then analysed these narratives using a model of skill acquisition developed by Dreyfus and Dreyfus (1980) based on the study of skill acquisition of airline pilots. In doing so, she has been able to demonstrate many of the subtle, usually hidden complexities in nurses skilled practices of caring. These skills are integral to establishing, maintaining, and bringing to closure the skilfully and artfully developed nursing relationships critical to facilitating patients healing health and wellbeing. This process was followed through the developmental stages of nurse practitioners from novice, through advanced beginner, and competent, to proficient and expert.

One of these vital skills Benner (1984) has illuminated, is the perceptual origin of excellence in nursing practice. She asserts that, "perceptual awareness is central to good nursing judgement and that this begins with vague hunches and global assessments that initially bypass "critical analysis" (p.xviii). She further notes that "expert nurses know that in all cases definitive evaluation of a patient's condition requires more than vague hunches, but through experience they have learned to allow their perceptions to lead to confirming evidence" (p. xviii). Expert nurses "can get a gestalt of the situation"(Benner, 1984, p xviii). This is part of what is understood as intuition, and intuition has historically, as

with caring, often been attributed as some "natural", mysterious or even occult ability of women. Such suspicions in the past have lead to many women's deaths by burning at the stake (Erinreich & English, 1973). Another example Benner highlights is the importance of discretionary judgement. By this she means that, sometimes, expert nurses will make a judgement that the best course of action is not one normally dictated by the rules of the situation, and act on it. Benner points out that this is not a careless abandonment of rules but a skilled advanced understanding of the situation that allows orderly behaviour without rigid rule following.

Benner further explains that understanding the discretionary judgement exhibited by nurses at the expert level comes from examination of the differences between practical and theoretical knowledge, and their relationship to the importance of experience in the development of expertise. As described by Benner (1984), "knowing that" and "knowing how" have been identified as two different kinds of knowledge, there are many skills (know how) that we acquire without first "knowing that", such as swimming or riding a bike. As she sums it up "some practical knowledge may elude scientific formulations of 'knowing that.'. And 'know how' that may challenge or extend current theory can be developed ahead of such scientific formulations"(p.2-3). According to Benner (1984) then

> *Expertise develops when the clinician tests and refines propositions, hypotheses, and principle based expectations in actual practice situations. Experience…results when preconceived notions and expectations are challenged, refined, or disconfirmed by the actual situation. Experience is therefore a requisite for expertise (p.3).*

This indicates that it is largely practical clinical experience, and of course reflection on that practical experience, that provides for the development of

discretionary judgement in expert nurses. Benner further notes, "theory offers what can be made explicit and formalised, but clinical practice is always more complex and presents many more realities than can be captured by theory alone." (1984, p.36). She goes on to explain in more detail that

> *A nurse who has dealt with many people acquires a rich basis on which to interpret new situations, but this multifaceted knowledge (like that of caring) with its concrete referents cannot really be put into abstract principles or even explicit guidelines. There is a leap, a discontinuity, between the competent level and the proficient and expert levels (Benner, 1984, p.37).*

This leap or discontinuity is where both the role of perception in skilled performance, and discretionary judgement comes in, as according to Benner, it is not that the rules simply become unconscious, it is that the rules are dropped completely. She further explains that in the Dreyfus and Dreyfus model, when the airline pilots reached this stage "their deviation from the rules allowed the instructors to perform faster and better. Thus indicating that with experience and mastery the skill is transformed" (Benner, 1984, p.38). This change according to Benner (1984) results in a whole new level of performance, and interestingly, according to the findings of Dreyfus and Dreyfus, if these expert pilots are made to pay attention to the rules that they may have used as beginners, their performance actually deteriorates (Benner, 1984, p.38). I have presented considerable detail in this section, which although it may be familiar ground to some readers, has been included to emphasise that nurses relationships with their patients, and the caring practices within them, constitute formidable, complex, intellectual, emotional, and practical skills that have taken considerable time and effort to achieve. At the proficient and especially the expert levels of caring practice in nursing, where the caring relationships seem to flow effortlessly from these nurses, can thus be easily

overlooked and undervalued. As a final point in this regard, again from the work of Benner, (1984) she states that

> *As long as the practices of experts in a field go unnoticed and undocumented, and as long as the development of clinical expertise is limited by short clinical careers, an essential link in theory development in nursing will be missing (p.37).*

A nursing perspective of caring and relation

Caring requires relation whether it is with self or other (Buber, 1970), and in nursing, the nurse-patient relationship is both constituted by and contains the nurses caring practices. Thus nursing is indeed about being in relation, whether briefly or for a lengthy time, and given the diversity and scope of nursing practice the nurse-patient relationships encompass a wide range of relations As such a central part of nursing the nurse-patient relationship has been the focus of research and studies, for example Peplau (1969); Roach (1987); Watson (1988); Vezeau & Schroeder (1991); Pollack-Latham, (1991). A number of nurses have selected the work of Martin Buber to express for them the remarkable nature of this relationship. Buber's (1970) ideas of the intense and intimate I-thou relationship as outlined in Chapter Two, may seem to imply too greater intensity and intimacy to be appropriate as a model for the nurse-patient relationship. Kuhse (1997), criticises nurses' use of Buber's work for exactly this reason. She states that "it would be quite unrealistic to suggest-as many nurse theorists do-that the nurse-patient relationship ought to be of the "I-Thou" kind." (p.148). And further, that there is "a great danger in requiring that every nurse-patient encounter be a 'total encounter' and in thus setting the ideal of caring in nursing too high" (p.149). Kuhse makes a good point, in that it is important to have realistic standards, goals and ideals to provide guidance, direction, and motivation. As Greenleaf (1991) previously pointed out, it is also important to understand that setting unrealistic expectations or ideals for caring

opens up very negative possibilities for the blaming and scapegoating by others of those unable to reach them. Other effects at the personal, individual level are self-condemnation and burnout. However, Kuhse is in fact missing a vital point regarding the real nature of caring as understood by nurses who have actively been in the nurse-patient relationship.

As Benner (1984) has established the nurse-patient relationship "is not a uniform, professionalised blueprint but rather *a kaleidoscope of intimacy and distance*" (my emphasis) (1984, p.xxii). To put it another way, it is not necessary for every contact between nurse and patient to be a total encounter of Buber's I-Thou kind, but what is important is that there is the potential for that kind of encounter to occur. The consistent actuality of an I-Thou relationship in the nurse-patient relationship is not required, but the openness to the possibility for it is. I believe this openness and possibility is gradually developed refined and carried within the caring practices of the expert nurse. Martin Buber's relational philosophy and ideas addresses exactly this potential and possibility inherent in relation. Berry (1985), in his book "Mutuality: The vision of Martin Buber", explains that in Buber's philosophy

> *…in the sphere of the human…there is no person, no situation, contact, or involvement with another human being that is excluded from the possibility of being a partner in dialogue-from the most fleeting and occasional, to the most stable and enduring. All discussion of degrees and limitations on full mutuality must begin with this recognition of the universal human possibility of relation (P.42).*

Thus Berry explains that the fullness of mutuality is not inherent in our life together, but its possibility is. He quotes Buber saying that, "it is a grace, for which one must always be ready and which one never gains an assured possession"(Buber as cited in Berry, 1985, p.42).

There appears to be a parallel between Benner's (1984) description of the nursing relationship being a kaleidoscope of intimacy and distance and Buber's philosophy of relation where Buber explains that "two movements are required for mutuality: distancing and entering into relation. Modification of either movement will qualify the degree of fullness which is possible in a given relationship" (Buber as cited in Berry, 1985, pp.42-43). The closeness of these two ideas is clearer if you substitute 'intimacy' for 'entering into relation', and 'kaleidoscope' for 'modification of either movement'. Buber's philosophy is also close to nursing practice in another aspect. Berry (1985) points out that Buber acknowledges the particular case of relation in "the helping role". He says that for Buber

> *Mutuality arises in the sphere of the interhuman on two levels. The first is that level on which we have to do with another person without any defining task or role to be played out or performed, where mutuality is most fully possible. The second is that level on which we have to do with another person, where mutuality is genuinely possible but where we are prevented from becoming fully mutual… which is occasioned by the presence of a task or a special defining role that is necessarily involve (p.41)*

The prevention of being fully mutual comes from a one-sidedness, an inequality stemming from the task or defining role. According to Buber "a person becomes a patient by virtue of seeking assistance in dealing with a need from someone who can be counted on to help" (p.48). Further to this the nurse or therapist does and must do something "that the patient cannot do" (Katz as cited in Berry 1985), and this something that the patient cannot do "is precisely that which imposes a normative limitation on the mutuality possible"(Berry, 1985).

The nursing relationship does have a defining role and a task. As previously noted, it is established with the purpose of facilitating healing and health (Newman, 1986). Nurses intentionally attempt to create caring relationships that are not and cannot be standard blueprints but are uniquely co-determined with the other person involved, for each nurse-patient relationship (Vezeau, 1992). Out of a partnership relationship with each patient (and often the family are involved as well) an environment is created with the hope that healing may occur (Benner, 1984). Indeed, there is not a guarantee that healing will happen but in my experience and the experience shared by colleagues, most of the time it does. Reading the practice exemplars presented by Benner (1984) gives at least some confirmation of this. Some of the time, that healing is transformative and transcendental in nature. This understanding of some transformative and transcendental healing occurrences, encountered in nursing caring practices, has been written and researched by many nurses and nursing theorists and scholars (Benner, 1994; Benner and Wrubel, 1989; Phillips and Benner, 1994; Vezeau, 1992; Watson, 1988;). It is also found in countless anecdotal narratives shared by other nurses from their experiences of caring relationships in their practice.

The practical reality of the nurse patient relationship is often, but not always, quite remarkable, intense, and despite the opinion of Khuse (1997), transformative and transcendental as Buber (1970) has described the I-Thou relation can be. It may not always be totally fully mutual and reciprocal, rather a matter of degrees, but even in fleeting encounters with the appropriate context, as well as the longer ones, it can and does happen. According to Benner and Wrubel, (1989), "Nurses provide care for people in the midst of health, pain, loss, fear, disfigurement, death, grieving, challenge, growth, birth, and transition on an intimate frontline basis. Expert nurses call this *the privileged place of nursing*" (p.xi). Bowden (1997) in support of this perspective sees that "nurses participate in the parts of peoples' lives when they are most vulnerable, when there are fewer possibilities to hide behind appearances, and when

everything that makes life most meaningful is at risk." (p.119). As Griffin (as cited in Bowden 1997) states, "Nurses are party to human possibilities that many other persons never experience or observe."(p.119).

That some nurses have found a resonance between their work and the philosophy of Martin Buber appears, in this light, not so surprising nor would it seem inappropriate. Even though Buber has explained that relationships that are task or role defined are to some degree limited in their ability to be fully I-Thou, or fully mutual, Berry explains that "There are also many gradations in the realm of I-Thou"(p.54), and finally he emphasises that

> *The presence of a task to be performed does not seal the borders of mutuality, but creates a difference that is qualitative rather than quantitative relative to the nature of the encounter… that… is not a distinction to be measured, but a recognition that each relationship is open to mutuality in its own peculiar way (Berry, 1985, p.68).*

The relational connection in the caring nurse patient relationship is obviously an integral fundamental part of, as Benner (1984) would say, the power and excellence of nursing practice. Benner also found that skills of developing and managing the balance of involvement in the relationship, was a key factor in moving nurses through the growth process from novice to expert. However, it still remains that there is, as pointed out previously, a one-sidedness and inequality arising from the differences in knowledge, culture, and the relative differences between the vulnerability of the person seeking help and the power and professional authority of the nurse. These differences can be mishandled through ignorance, inexperience, or stress, and in some very unfortunate cases exploited deliberately causing real trauma and damage. Gorovitz (1994) points out that " the time a person spends as a patient is a part of that person's life; the quality of that time therefore is an ingredient in the quality of that life" (p.131).

Gorovitz further emphasises that quite apart from major problems resulting in lasting damage caring is important because

> *A patient who feels demeaned, ignored, depersonalised, diminished by unacknowledged delays, discomforted by rough handling, frustrated by failed attempts to communicate, or embarrassed by insensitive behaviour, is harmed- not necessarily in lasting ways, but in ways that are objectionable simply because they constitute avoidable diminutions in the quality of someone's life (p.131).*

Nurses are acutely aware of the points Gorovitz makes, they care about that quality of life. Nurses are educated from the beginning of their basic education to be aware of the power difference in the nursing relationship, the physical, social, and cultural vulnerability of the patient. It is the individual levels of caring and the degree of commitment to nursing's ideals of caring, that to a large extent determines how these power and knowledge and cultural differences are handled by the nurse (Benner, 1984; Benner & Wrubel, 1989) In her narrative exemplars of nurses' actual practice presented in "From Novice to Expert", Benner (1984) found the nurses in her study were indeed acutely aware of their patients' vulnerabilities and did not take advantage of this power difference. Falk Rafael (1996) has also found that in the main, nurses use their power to enable and empower in order to assist in healing. She goes on to say that "enabling power is based on respect for the diversity among people" (p.14), and quotes Chinn's description of this conception of power saying that "it is characterised by valuing the personal power of each individual, and is illustrated in decision making by consensus in which each person's perspective is heard and considered" (Chinn as cited in Falk Rafael, 1996). Nurses work hard to protect the dignity, and integrity of their patients. They try to build trust through honesty and openness, by sharing themselves as human beings (Benner, 1984). In sharing their common humanity appropriately they thus

create a bridge between the different worlds of the nurse and patient through which caring and assistance can be offered, made accessible and acceptable, and thus able to be received by the patient. Again it is aspects of Buber's vision of mutuality that supports and explains this facet of nursing practice. As Berry (1985) explains that in interpreting Buber's vision it is understood that

In all the situations defined by the working out of a purpose, the helper also needs help, or at least should be understood as potentially needing help. Living out a purposive relationship in the light of that recognition can empower the implementation of the defining task without the rigid sense of hierarchy which is always the enemy of mutuality. While the helper accepts the asymmetricality of the relationship, he or she can thus open the self to be affected by all the impulses that proceed from the person of… the patient… That is possible because power over the other does not belong essentially to this archetypal situation. The central fact is for the healer to be able to affirm his or her own woundedness… This should give the patient and the therapist a way of regarding with equal authority and equal validity the way in which they see life. (p. 60)

To see this understanding put back into the frame of nursing practice, where it is incorporated into the fundamental characteristics of the nursing perspective of caring, Parker (1991) eloquently sums up that

The heart of nursing lies in the quality of the care which is delivered and which is premised on a recognition of the mutuality of the nurse- patient relationship, on the moral stance of the nurses and on empathy and understanding of the human vulnerabilities and frailties of people cast into patient and client roles... Nurses attempt to take into account the complexity of the life situation, life history, and life circumstances of people in their care and try to grasp in a holistic way the often complex, contradictory, and uncertain situations in which they find themselves in the planning and delivery of care. (p. 288)

However, what is vitally important to remember, is that nurses are not the only health care providers with responsibility for the patients' quality of life experience within the health care system. Doctors, physiotherapists, even clerks, receptionists and many others all have a share, along with the institutional organisation and its general ethos.

Given the issues of trust, honesty, and vulnerability involved in the caring practices within nurse patient relationships, the very ethical nature of nurses caring practices becomes clear. It also becomes clear that in reality the ethical aspects of caring cannot be separated out in the way that I have presented them in this chapter for purposes of clarity. It is not just caring practices that are basic to nursing but ethical caring practices, which will now be explored.

A nursing perspective of the ethical aspects of caring and an ethic of care

Caring is held to be the moral basis of nursing (Leininger, 1990; Fry, 1989, 1990, 1991; Watson, 1985, 1990a, 1990b; Watson & Ray, 1988; Yarling & McElmurry, 1986). The fundamental aspect of this ethical perspective is "the relational context in which nursing care must be situated… the nurse enters as a person into a relationship with the patient" (Gastmans, Dierckx de Casterle & Schotmans, 1998, p. 48). Caring relations are historically and contextually embedded, they involve trust and mutuality in varying degrees of intensity, as discussed previously, involving the whole person of both the nurse and the patient. This inevitably means responsibility, accountability, and risk. Here people's lives can be at stake including the nurses lives. Parker (1991), eloquently expresses this

> *Ethical decision-making for nurses is then based upon an ethic of responsibility*
> *towards oneself and others, and towards the natural and socio-cultural*

environment… It acknowledges that nurses are not detached neutral observers of the situations and circumstances in which they practise. The practice of nursing as a craft wherein nurses come into a caring, healing, nurturant relationships with troubled, vulnerable, sick, and hurting people requires nurses' involvement, commitment, and insight, as well as their skills and knowledge (p. 305).

In the words of Gastmans (1999) "care can be considered as a foundational normative concept in the ethics of the nursing profession" (p.214).

The basis for considering nursing as a moral practice, lies within the actual realities of its practice (Fry, 1989; Hinson Penticuff, 1991). Nursing, in being a practice discipline that has been given a social mandate to provide caring for people in their experiences of varying health circumstances, is directed towards the personal and social "good" (NZNO, 1993). In terms of Gadamer's view of practice, nurse's caring practices are "human action directed by communal ways of being, aimed at promoting human good" (Gadamer as cited in Bishop & Scudder, 1990, p.71) This is because according to Gadamer as cited in Bishop & Scudder, (1990) practices "are the bearers of intentionality that spring from participation in cultural groups with common meaning and values (p.71). Nursing is a cultural group that values caring as primary (Benner & Wrubel, 1989), and that collectively, intentionally chooses to direct that caring to helping their patients (being individuals or groups) find meaning and healing in their health experiences ranging from birth to death. According to Benner, (1991) "the dominant ethic found in stories of everyday practice is one of care and responsibility" (p.2). A more recent study in New Zealand by Woods (1997) "Maintaining a Nursing Ethic: A grounded theory of the moral practice of experienced nurses", also clearly outlines that an ethic of care, though not exclusively, underpins nurses' moral practice. Tanner, Chesla and Gordon as

cited in Benner (1991) give a definition of this caring related to the specific context of ethical nursing practice as

> *the alleviation of vulnerability; the promotion of growth and health; the facilitation of comfort, dignity, or a good and peaceful death; mutual realisation; and the preservation and extension of human possibilities in a person, a community, a family, a tradition (p.2).*

Nurses develop the abilities and ethical comportment to do this by being able to draw from their accumulated store of experiences of skilful ethical caring practices developed within the previous partnerships of nurse-patient relationships. According to Benner (1991) ethical comportment refers to

> *the embodied, skilled know-how of relating to others in ways that are respectful and support their concerns. Comportment refers to more than just words, intents, beliefs, or values; it encompasses nuances such as stance, touch, orientation-thoughts and feelings fused with physical presence and action (p.2).*

They employ what can be called practice wisdom to discern the greater, and also exquisitely small differences between previous situations and this particular one. As Benner describes it this practice wisdom or experience "is gained when one actively learns to recognise salient ethical distinctions in practice with particular patients and families" (p.2). Further to this Benner explains that "in practical ethical reasoning, clarity rests in a situated knowledge of the person, family or community" (p.3), and employing the ideas of Taylor as discussed in Benner (1991), Benner adds that "this particular knowledge reflects practice-based understanding of the good and its violation"(p.3).

Nurses assess and choose from the plethora of practical experiences of what has and has not worked in the past, to come up with the plan most fitting and appropriate for action (or inaction) depending on the situation. As Benner describes it

> *With experience, the concrete situation becomes coherent, and the practitioner creates a narrative of doing better or worse, of recognising similarities and differences, and of participating in common meanings, practice narratives, and practices that allow the practitioner to recognise common clinical entities and issues (1991, pp. 2-3).*

This narrative of doing better and doing worse assists the nurse in the responsibility of choosing and deciding involved in the contexts of their nurse-patient relationships. Ultimately the nature and outcome of these relationships depend on the choices and decisions made within it: a simple, seemingly obvious point, but it has fundamental significance as it points directly to the ethical aspects or the aspects of "the good" of nurses' caring practices.

To explore this important point further, Gadamer (as cited in Bishop and Scudder, 1990), holds the view that choices constitute practice. He explains that, "human practice exists… when a free citizen makes a decision, and that decision takes its bearings by the order of preferences guiding ones conduct" (p.73). He further explains that

> *practical knowledge involves knowing what to prefer among human values and how to choose that preference actively as an individual in community", and that, " 'in deliberating and taking counsel' in 'guiding action,' the preference or the deliberation has to be guided by its relationship to the good" (Gadamer as cited in Bishop and Scudder, 1990, p.73).*

Applied to nursing, it can be seen that nurses caring practices involve deliberations and preferences (choices), that are guided, by a perspective of care, because from their previous personal experience, and developing practical knowledge (practice wisdom) they have learned to actively value, that is prefer, and so choose caring because for them it has demonstrated a primal relationship to "the good".

The nurse and patient reciprocally influence each other in growth and development through out the ongoing choosing and decision making processes of the caring relationship. Therefore it can be seen that even the small ordinary day-to-day decisions are *ethical* (my emphasis) decisions (Benner, 1991). The ethical nature of the everyday decisions in nurses caring practices implies then, that ethical caring practices are a way of being, and not something produced only in an ethical dilemma or problem situation. In the study by Woods (1997) mentioned previously, regarding the moral practice of experienced nurses, he found that morally competent nurses do not make ethical decisions in practice by trial and error, as may be the case with uncaring or inexperienced nurses, and they didn't merely copy the approaches of the medical profession. According to Woods (1999)

> *The modus operandi of professionally experienced and morally competent nurses is more likely represented in an ethic that is traceable to early days in nursing, but then adapted, modified, improved and developed into a truly professional nursing ethic. (p.6)*

Woods (1999) goes on to explain that this distinctly nursing ethic is what "serves as the central *guide*, or *driving force* behind every moral decision and action of morally competent nurses" (p.6) He concludes that this nursing ethic

has its "origin, development and effect in practice" (p.6), and joins Benner (1991) in soundly establishing that expertise in skilled ethical comportment is gained in actual practice. This is not to say that theory has no part in nurses' ethical development. It too is important, for guiding beginners while developing their nursing ethic, and also for dialogue with those health professionals whose main ethical approaches are theoretical.

Woods (1997) points out, as does Benner (1991), that this has great significance for the teaching and the ethical development of nurses within the nursing education process. The nursing education process is where student nurses who come to nursing as unique individuals with their own histories (and own prior moral experience) are enculturated with the agreed upon and shared conceptualisations of caring and ethical caring, amongst other fundamentals, into nursing. (Woods, 1997, 1999) It is the sharing of these conceptualisations of caring and ethical caring practices, transmitted by theoretical and practical engagement, role models, mentoring, academic studies, practice narratives, standards for practice, and codes of ethics which also serves to develop nursing as a community.

Benner (1991) pointed out ethical caring practices are defined as "…skilled actions that have a notion of good embedded in them because they are lodged concerns lived out in a community with a narrative and a tradition" (p.2). This living out in a community with a narrative and a tradition also serves to support, sustain, and reinforce the nurses' commitment to caring ideas and ideals. This occurs, as Benner (1984, 1991, 1994) has pointed out, in several ways; it is achieved through the satisfying occurrence of those relational events in the degrees of mutuality between nurse and patient, when the mundane and the transformative and transcendental healing is witnessed. Also, from nurses' exposure to role modelling, and observing the excellent ethical caring practices of experienced expert nurses (Benner, 1984) This is why experienced expert

nurses are a near priceless nursing development resource. Much damage has been done to nursing by these nurses leaving the workforce, in the context of the Western phenomenon of importing into health care neo-liberal marketing ideology, values and strategies, that do not see, recognise or support their valuable skills. (Benner & Wrubel,1989; Carper, 1979a; Phillips & Benner, 1995).

The internal nursing education, enculturation, and development of a distinct nursing ethic in morally competent experienced nurses (Woods, 1997) all support nurses' ethical caring practices. This gives considerable strength to enable nurses to continue nursing, to the best of their ability in the "complex, contradictory, and uncertain situations" (Parker, 1991) that nurses frequently find themselves in. However, there are still formidable difficulties, and negative aspects to sustaining and maintaining ethical caring practices. There is already the difficult in-between position of different and divided loyalties, and different levels of authority to answer to. The nurse must balance and manage, nurse-doctor relations, nurse-employer relations as well as the nurse-patient (and their family) relations. This further constrains nursing's relative autonomy and ability to be moral in the organisational workplace as identified by (Yarling & McElmurry, 1986). Even the nurse-nurse relationship can be a source of distress. How to approach situations of observed bad nursing practice, and there is horizontal violence amongst nurses themselves classified by feminists as classic oppressed behaviour. Relationships between doctors and nurses to do with hierarchical power, gender, status, valuing and recognition make being a patient advocate very difficult at times. The often pointed to differences in perspectives of care verses cure between medicine and nursing is a simplistic and unhelpful dichotomy as both nurses and doctors actually do both, and value both (Gillon, 1992 Jecker & Self, 1991). However, the relative weights given to each and the power and enduring predominance of the curative and technologically oriented model of medical care are still a problem of major significance, especially in the field of palliative care (Fox, 1997).

Apart from power abuse issues there are other negative aspects in the nursing perspective of the ethical aspects of caring and an ethic of care. Many nurses find caring and an ethic of care unsuitable for adoption by the discipline as fundamental, (even though it is evident as a major part of what they do, because they do not fit with their emancipatory drive for scientific recognition (Benner & Wrubel, 1989). The emphasis on scientific evidence is still present in some areas of nursing, where there is a very narrow understanding of the kinds of evidence acceptable for evidence based practice (Watson et al, 2001), Those nurses significantly concerned with the drive for more autonomy and professional recognition, feel that emphasising caring and an ethic of care could undermine their quest because of the connection between women and caring and the undervaluing of both. Finally as previously mentioned, the complex, powerful influences of the social and political context in which both the healthcare system and nursing are embedded.

However, it remains that there is a wealth of promise in the nursing perspective of caring and an ethic of care, as Benner (1984) has said, examining the practice of skilled experienced expert nurses holds much promise for nurses and nursing as a discipline. It also would seem that there would be much that would be of relevance in other areas besides nursing, for example, in contributing to knowledge and understanding of caring more generally in terms of the wider society. Perhaps the direction of the macrocosm to microcosm dynamics between society at large and the healthcare arena could be reversed so the value and influence of ethical caring practices flows from micro to macro? However, there are undeniable difficulties that nursing is continuing to wrestle with. In juxtaposing the feminist and perspectives on caring and an ethic of care, there is some evidence that a dialogue between the two could be fruitful in creating ways that the perspective of one could highlight new possibilities and solutions for the other and vice versa. This is again a whole

field of inquiry too extensive for inclusion in this study. However, some insights can be found in a brief view of the similarities and differences of the two perspectives.

Nursing and feminist perspectives: Discussion of similarities and differences

A nursing perspective of caring and a feminist perspective of caring are two separate and distinctive perspectives, however they do have a number of common features. Nurses, in a female dominated profession, who make up by far the largest group of providers of caring work throughout the healthcare system (Johnstone, 1999; Tronto, 1993) share many points of connection with the oppressive experiences of other women existing in a patriarchal society. According to French (as cited in Falk Rafael 1996) "the denigration of women and that which is feminine has been entrenched in all of civilisations major institutions" (p. 6). The healthcare system is no exception. Johnstone (1999) explains that just as, historically, woman have been treated as the subordinates of men, and their moral concerns and viewpoints have tended to be marginalised, trivialised or invalidated, so too have nurses' viewpoints tended to be marginalised, trivialised or invalidated and nurses have been treated as the subordinates of (medical) men. According to Falk Rafael (1996) many nurses remember being taught deference to physicians in nursing school, and she points out that loyalty to the physician remained an ethical requirement of the International Council of Nurses until as recently as 1973. Johnstone (1999) points out "although not always recognising it, nurses have had first-hand experience of the kind of negative and harmful consequences that can flow from a constraining gender-distorted (masculinist/malestream) view of the world." (p. 133).

In some respects the negative aspects for nursing are even more profound. The circular, devaluing "catch 22" association of women with caring, as outlined previously, serves a double measure for nurses. Nurses choose to care as a

profession and extend their caring beyond the usual relationships of family and friends to complete strangers, in a societal position that spans both private and public realms but does not fully belong in either. Because of this nurses have been regarded with some suspicion by feminists as noted previously, who see this choice as supporting and perpetuating patriarchal oppression and as an exploitation of women's caring (Tong, 1993; Bowden, 1997).

At the same time nurses' caring practices within the healthcare system are subordinated to medical practice, and the needs of the institution therefore they rarely get to influence policy or institutional practices from a position entailing some degree of autonomy (Scott, 1998; Johnstone, 1999). The fact that nurses provide comprehensive care is still largely accepted as, "a feminine virtue and duty deemed necessary but devalued" (Falk Rafael, 1996, p.9). A nursing perspective of caring, therefore, comes from a position of nurses maintaining and valuing care as an essential, if not the essential, feature of their profession within a context that accepts all that caring can provide for facilitating peoples health, and quality of life and death while compartmentalising and devaluing it. This necessarily can and does create in some nurses' conflicts, frustration, depression, loss of morale leading to perpetuating the debilitating problems of burn out, horizontal violence, and loss of the commitment and the ability to care well for their patients, their colleagues, or themselves. The work done by Benner and Wrubel (1989) on stress and coping in health and illness, points to approaches to dealing with these problems. Benner and Wrubel explain that in their view

> *The risks and vulnerabilities inherent in caring lead to the temptation to create safe places of "controlled caring" where the person dictates fully what matters and exercises the freedom to stop caring where the person or project is threatened. Many coping strategies are designed to increase distance and control. However, if such strategies are inappropriately used and understood to*

mean that detachment is always preferable and least stressful they effectively rob the person of the possibilities and meanings inherent in caring (Benner & Wrubel, p.2).

This understanding is very helpful and provides an answer, but as other nurses such as Greenleaf (1991) have pointed out there is a problem with successful implementation of this approach if the contextual situational support and valuing of caring is not present. What the feminist perspective contributes to this situation is the study and understanding of the wider contextual influences society that do not always provide adequate support, no matter how hard a person or nurse tries to deal and cope with finding positive strategies. However following the feminist argument that revaluing and increasing the status of caring should not be done because it perpetuates patriarchal domination, is not an answer either.

This position in the feminist perspective of caring and an ethic of care can be understood in part from their political point of view, but this is too simplistic an assessment. The nursing perspective of caring would argue that the importance and necessity to human survival of caring is such that it should be valued regardless (Benner, 1984, 1994; Leininger, 1990; Watson, 1990). The results of not valuing caring logically leads eventually to a lack of and in some cases complete absence of caring. The evidence of this lack stares people in the face everyday and is increasing, as is social fragmentation (Beaglehole & Bonita, 1997). Nurses, in particular, ultimately have to deal with in their practice with child neglect and abuse, domestic abuse, poverty and all manner of psychological disorders. Despite this and despite the successful work and research in valuing caring and helping it to become more visible by many nursing scholars, much of it still does not effectively address the multiple constraints in the context in which the caring and ethical practices of nursing are carried out.

Bowden (1997), in her study of nursing as an example of a caring relationship makes some very valid observations. Her study demonstrates respect for the wonder of what nurses manage to do with their ethical caring practices as she observes how they are constantly balancing and negotiating "…the tensions between integrity and dependency, responsibility and control as well as mediating the interconnected aspects of patients' subjectivity and objectivity, interposing the often conflicting aims of physiology and the spirit, science and humanism" (p.104). Bowden further points out that this complex caring, is carried out by nurses while situated in a difficult position. Her observations on this fact essentially echo and expand on the original work of Yarling and Mc Elmurry (1986) and also the in-between position originally identified by Bishop and Scudder (1990). However, unlike their positive interpretation of it, she sees this position as distinctly detrimental. She examines much of Benner's work and values it highly for its clear exposition of what do nurses actually do, in the particular situations in which they care for their patients. However, she notes that the importance of care is demonstrated but not the means to lift it beyond its constraints and distortions and negative aspects.

According to Bowden "most notably, nursing relations are usually characterised by exceptional functional interdependence and overlap with other relations in healthcare… they are infused with the tensions of sustaining interdependent but differently focused relations with different levels of authority" (p.104). She sees that relations with patients are closely tied into relations with other members of the institution and the gendered social order is a crucial constitutive factor in the practice of nursing. Further to this she sees that "in keeping with the dominant norms of this order, nursing care is incumbent with much of the social apparatus that operates to undermine both the value of woman's practices in general and the social possibilities of the

practitioners. In particular this includes the largely invisible, ethical significance of nursing as a caring practice (Bowden, 1997).

For change to occur, Bowden sees that valuing care and making it visible are vital but not sufficient. For the real possibilities of caring to be actualised the structures within which nurses ethical caring practices are carried out must change. It comes down to the fact as stated previously that all people need to be cared for regardless of gender, cultural differences, and politics (Benner & Wrubel 1989; Bowden, 1997; Tronto, 1993). It seems that caring itself may not the problem, but the lack of support and resources and the overwhelmingly unfair distribution in society of who does the caring. Addressing this should be the focus, and many feminists and nurses alike now focus on this. In fact many nurses adopt and combine a feminist perspective of caring along with their nursing perspective of caring for example Wheeler and Chinn (1989), and Watson (1990b). This combination along with closer interdisciplinary dialogue with the feminist perspective appears to hold possibilities worth pursuing.

Summary

It can be seen that a nursing perspective of caring existing as a plurality of views consists, like the feminist perspective of caring, of both positive and negative aspects. Both have degrees of difficulty with the demonstration and articulation of the importance of caring and the ethical aspects of caring, but no difficulty in knowing and understanding it to an advanced degree from a lifetime of association. It would seem that the more political approach of the feminist perspective of caring would have something of value to offer the nursing perspective, while the nursing perspective with its total immersion in the intricacies of ethical and purposeful caring relations and their indubitable impact on the health healing and survival of human beings would have something of value to offer a feminist perspective of caring.

There appears to be a need to come to terms with and accept that some of the most fundamental essentials for human health and quality of life are not entirely, rationally explicable or measurable or quantifiable. However, they are no less essential, valuable and vital. Caring is still recognised organically and utterly by humans none the less. They are known and understood unequivocally in the experiential realm and can be seen and measured more accurately by their sequelae, jobs, productivity, health, ability to cope, survive, adapt better and faster to change and challenges.

It is time now to leave this part of the study focusing on caring, the ethical aspects of caring and an ethic of care to examine and explore the realm of bioethics. It is necessary to now focus on getting familiar with the nature of bioethics in order to progress with the aim of developing some understanding of what place, if any, caring may have within it.

CHAPTER FOUR

BIOETHICS: AN ORIENTATION TO THE PRESENT FROM A TELESCOPIC VIEW OF THE PAST

To understand the present we must journey into the past (anon.)

Introduction

This chapter is concerned with beginning to lay out a view of the landscape of bioethics in order to see how caring might have a place within it. On entering into the bioethical literature for this study it soon became obvious that bioethics has developed into a complex and intricate field. There are broad descriptions of bioethics that may be acceptable at a surface level. For example, bioethics can be defined from its etymological roots as 'ethics applied to the bio realm', where bio comes from the Greek 'bios' meaning life (Reich, 1978; Johnstone, 1994; Gillon, 1998). However if one is looking in more depth at what constitutes the field of bioethics, or 'doing bioethics' a clear understanding is more difficult to obtain. It tends to depend on what period of its historical development is the focus, and which of the many different approaches or perspectives of bioethics is being used at the time. This is further complicated by a rather confusing usage of much of the terminology. Therefore, to provide a rich account of bioethics present day manifestation(s), this chapter, the first of two focused on bioethics, will provide the following: clarification of some of the important terminology, and of the general characteristics of bioethics; an outline of the influential history concerning bioethics genetic roots in early philosophical and ethical thinking, and finally the more recent history of the development and establishment of contemporary bioethics.

Clarifying important terminology and identifying the general characteristics of bioethics.

The term bioethics was first coined in 1970 by a biologist and cancer researcher Van Rensselaer Potter in his book *Bioethics: Bridge to the Future*. For Potter the term originally represented the combining of ethics, which he saw as belonging to the humanities, with biological knowledge from the sciences to create a new interdisciplinary ethics. It was Potter's belief that the rapid advances in technology occurring circa 1970, required the guidance and wisdom that an interdisciplinary bioethics could provide in order to improve quality of life and ensure man's (sic)survival on earth. At almost the same time and apparently independently, according to Gillon (1998), the word bioethics was used in a somewhat different sense by a Dutch foetal physiologist and obstetrician Andre Hellegers. Hellegers, along with others, founded the Kennedy Institute of Human Reproduction and Bioethics at Georgetown University Washington DC in 1971. Hellegers used the term bioethics with a narrower focus to apply to the ethics of medicine and biomedical research. Thus from its establishment there were two quite disparate concepts of bioethics, one narrow in focus conceiving of bioethics as traditional ethics applied to increasingly complex ethical situations in medicine and biomedicine. The other, much broader in scope, conceiving of bioethics as the creation of a new interdisciplinary discipline to provide guidance in the face of burgeoning technological advances, and their potential impact on humanity and the environment. This disparity, according to Gillon (1998), highlights a fundamental disagreement over what constitutes bioethics that can be a source of confusion in working with bioethical literature if it is not understood.

It was the narrower focus on medicine, and biological research that directly related to medicine, that was the first and major component of bioethics (Pellegrino, 1993; Gillon, 1998), and it appeared to stay this way for some considerable time. It is interesting however that in a literature search of contemporary bioethical texts in the Victoria University of Wellington Library,

some foundational 1970's bioethical texts that shared the same noted bioethical author were found separately, one in the medical section and the other in the biological science section. In the biology section "Contemporary Issues in Bioethics" published in 1978 and co-authored by Tom L. Beauchamp, was found together with Van Rensselaer Potter's book "Bioethics Bridge to the Future". In the medical section, also co-authored by Tom L. Beauchamp with James Childress and published in 1979 was " Principles of Biomedical Ethics", often referred to as "the bible" in medical and health care ethics.

This provides some evidence that there has been awareness of the existence and validity of the other broader conception of bioethics, presumably developing parallel to but overshadowed by the narrower medically focused version. In the first Encyclopedia of bioethics published in 1978, the Editor in Chief, Warren T. Reich, defined bioethics at that time as

> *… the systematic study of human conduct in the area of the life sciences and healthcare, insofar as this conduct is examined in the light of moral values and principles (Reich, 1978, p. iv).*

This reflects the narrower conception in ascendance at the time, as Reich (cited in Koczwara & Madigan, 1997) stated, "Many scholars and much of the public tend to identify the scope of bioethics in a somewhat narrow medical sense' ". (p. 76). However, the balance between the two conceptions of bioethics is now changing. The main reason for the change is the pressure of the very rapid growth and expansion of bioethics since the 1970's resulting in the inclusion of a much wider range of subject matter, and a greater number of different participants and disciplines (Gillon, 1998). In philosophical terms, these changes have taken place in a remarkably short time, as Koczwara and Madigan (1997) point out that The Encyclopedia of Philosophy has remained unchanged for 30 years, whereas in fifteen years (approximately) the comprehensive changes in

the field of bioethics created the need for a substantial revision of the 1978 edition of the Encyclopedia of Bioethics. In 1995 a new edition of the Encyclopedia of Bioethics was published in which Reich again as Editor in Chief, explains that it has become necessary to expand the definition of bioethics to

> *…a broader scope that would embrace the social, environmental, and global issues of health and the life sciences. Thus we see the field of bioethics as going beyond biomedical ethics to embrace health related, and science related moral issues in the areas of public health, population ethics, and animal care.'Reich (cited in Koczwara & Madigan, 1997, p. 76)*

This revision represents a move of the perspective considerably towards Van Rensselaer Potter's original broader conception of bioethics, thus indicating his original multidisciplinary conception to have been visionary at the time.

Indeed Potter's original conception consisting of two disciplines has been vastly surpassed. Bioethics now has a very multidisciplinary nature with the inclusion of disciplines such as moral theology, law, economics, psychology, sociology, anthropology, and history, to name a few, along with medicine, nursing and biology. It is the increase of new areas seen as relevant to bioethical enquiry, and then added to the field that continually stretch and change the boundaries (Gillon, 1998). This basic instability of the boundaries of bioethics along with the increasing cultural diversity of other contributing parties as it expands world wide, and the effects of multiple media influences, virtually ensure the inability to make any conclusive definition of bioethics (Gillon, 1998; Koczwara & Madigan, 1997).

The fluidity of the boundaries of bioethics is joined by a confusing interchangeable use of terminology as in the case of the terms applied ethics

and bioethics. In its infancy bioethics was often known as applied ethics because at that stage it could simply be described as the application of traditional ethical principles, (from the parent discipline of ethics), to increasingly difficult situations beginning to occur in medicine and related biological research (Gorovitz, 1992; Pellegrino, 1993; Winkler, 1998). However as traditional ethics are now applied to areas beyond medical ethics, and beyond healthcare in general, the term 'applied ethics' no longer represents only this area. In the Encyclopedia of Applied Ethics, Winkler (1998) defines applied ethics as "a general field of study that includes all systematic efforts to understand and to resolve moral problems that arise in some domain of practical life." (p. 192). The domain of practical life covered by applied ethics is, according to Winkler (1998), divided into the three major subgroups of bioethics, environmental ethics, and business ethics, each of which is divided into further subgroups of its own. In this view bioethics is now clearly recognised as only one part of applied ethics not the whole. However, in earlier definitions Weiss (1995) argues that environmental ethics is part of the field of modern bioethics, and Reich's (1995) expanded definition of bioethics, also includes the area of environmental ethics, providing evidence of an overlap of subject areas that could be claimed by either applied ethics or bioethics. The earlier definitions of bioethics incorporate the developing area of environmental ethics within bioethics, while the latest definition puts it in the broader applied ethics as a category of its own illuminating a further boundary change due again to the rapid growth, of environmental ethics which is now a very large and specialized area in its own right, with many sub groups of its own, for example, deep ecology and eco-feminism. (Gillon, 1998;Kheel, 1993; Winkler, 1998).

Clinical ethics is another term that is sometimes used as an equivalent or interchangeable term for bioethics in its entirety, for example Pellegrino (1993) uses the term "clinical bioethics". However clinical ethics is a sub branch of bioethics whose particular area of application is in the arena of clinical practice.

(Koczwara & Madigan, 1997). Clinical ethics developed as a distinct area out of the main body of the early form of bioethics in the late 1970's. According to Koczwara and Madigan, (1997), the term was first used in 1976 by Joseph Fletcher a philosopher and early pioneer of bioethics, in a lecture given at a medical school. He supported a form of situation ethics, which he felt was more appropriate to the practical aspects of medicine concerning a doctor and a patient as opposed to the application of general rules across the board. This focus on particular situations has become accepted as a distinct characteristic of clinical ethics. According to Gillon, (1998), the clinical approach is characterized by being highly particular, contextual, and partial, or as Koczwara and Madigan, (1997) more pragmatically put it, clinical ethics "…is directed at the care of a particular patient faced with a particular illness or injury" (p. 80).

In considering the existence of multiple conceptions of bioethics, in particular the major narrow and broader versions of bioethics, I detect an interesting parallel of sorts with the narrower and broader conceptions of health. I see a similarity in the paths of attempting to define both bioethics and health that indicates a more general trend in society as a whole towards greater complexity (Capra, 1972; Guba, 1991). For example initially there was a narrow definition of health as 'the absence of disease' which has slowly broadened and multiplied as scientists and lay people have become aware of the wider range of factors including the environment, genetics, personality, housing, relationships, employment, pollution etc. that need to be considered regarding a person's state of health (Beaglehole & Bonita, 1997). Just as with health, bioethics has also progressed from a relatively narrow definition to broader and multiple versions. In both health and bioethics few can agree on exactly what constitutes or defines either. At the present time in both bioethics and health there are those that still hold to the earlier narrower and more clearly apprehended definitions of each. It seems then, that there is a paradigm shift also involved adding to the complexity in bioethics, where the less new and the older versions of health and bioethics exist along with the new (Guba, 1990). Thereby the

potential for communication difficulties across different paradigms or perspectives and understandings of definition within bioethics is increasing.

In summary from its establishment in 1970 there have been two quite different conceptions of what constitutes the field of bioethics. One has a narrow focus on the application of traditional ethical principles in medicine and biomedical research. The other has a broad focus on the creation of a new interdisciplinary ethics, in order to provide wise guidance for the preservation of quality of life and human survival in the face of rapid technological change. The narrow medically focused version has held a dominant position for a considerable time, however its ascendancy is strongly challenged by the nature and rapidity of scientific and technological advances. It is the very nature of these scientific and technological advances, along with increasing multidisciplinarity, public and media participation, that cause the boundaries of bioethics to shift and change in ways that make it virtually impossible to develop a conclusive definition. These same factors create difficulties with multiple understandings in the use of bioethical terminology which combined with the many different perspectives, old and newer coexisting at the same time, can make ethical situations even more difficult to resolve. The positive side of these seemingly negative factors is firstly that in themselves they provide a set of recognisable characteristics with which the field of ethics can be broadly but usefully described. Secondly the lack of a conclusive definition of bioethics can be seen not as a frustrating failure but as a clear indication and appreciation of the complexity and rate of growth of a continually evolving field. Growth and development require at least some degree of fluidity in boundaries.

Genealogical influences in the history of bioethics

A number of the complexities and themes in contemporary bioethics result from the long reaching direct and indirect influences of its close genealogical relation to the disciplines of ethics and philosophy, ethics being the equivalent a

parent, and philosophy a grandparent. For a clearer understanding of this situation, the history of bioethics section is divided into two parts. The first with a focus on some of the important formative early history, from 500BC to World War II, and, the second, with a focus on the more recent history From World War II to the present.

The Early History 500 BC-World War II

Ethics developed in the Hellenic era initially within the general area of philosophical thinking and discussion thriving within the culture of ancient Greece at that time, later as it developed, it became a separate and distinct field on its own (MacIntyre, 1995). According to Norman (1995), it was the Sophists in the fifth century BC who were the first thinkers to raise questions about the idea of moral conduct, and about what morality is and why it should exist. As Norman, (1995) explains, the Sophists developed the idea that moral codes were useful human creations that they saw as "sets of customs and conventions which make social life possible and in doing so, committed themselves to a form of ethical relativism and to the denial of any universal code of morality or any absolute moral truth." (p.587). Some radical Sophists concluded that if traditional moral standards were mere conventions they have no binding force therefore why bother to be moral at all (Norman, 1995). It was Plato and Aristotle who took up the task of answering that question in a more systematic manner.

According to Bostock (1995), Plato's early dialogues were preoccupied with ethics and answering the fundamental ethical question how to live the good life. In particular Plato concentrated on finding the correct definitions for the traditional virtues of that time, temperance, courage, justice, and piety, for if they are good qualities it must be because they make a good life for those that possess them, and underlying all the virtues must be the ability to know what constitutes the human good (Norman, 1995). Norman further explains that in his "Republic" Plato proposes that the good life is found in the harmony of the

soul, a state achieved by the possession and balancing of the virtues, and since such a condition is one in which a person is happy and flourishing, the morally good life lived in accordance with the virtues is to be the best life for human beings.

This was also the time within the Greek culture when the powerful influence of the prototype of "theoretical" reasoning in the form of mathematical geometry began developing rapidly (Jonsen & Toulmin, 1988). According to Jonsen and Toulmin (1988), the rigor of Pythagoras's geometry and the mathematical method of formal deduction was so attractive for many Greek thinkers, Plato included, that it soon became the ideal of all rational argument at that time. Plato moved away from his interest in ethics to continue his work in the wider realms of philosophy, and greatly impressed by the rise and spread of geometry and formal mathematical deduction he devoted his work "Timaeus" largely to exploring mathematical theories (Bostock, 1995).

According to Norman (1995) although Plato's direct interest in ethics waned, Aristotle picked it up and became associated with virtue-based ethics developing it further. Although also influenced by formal deductive methods in many areas of his work, Aristotle strongly emphasised the practical nature of ethical thinking, he called into question "the assumption that moral reasoning and moral concepts can be—and should be—analysed in universal and invariable terms" (Jonsen & Toulmin, 1988, p. 281). In direct opposition to the precision of the formal mathematical deductive approach Aristotle emphasized the difficulty in being certain or exact in determining answers in ethical situations. Jonsen & Toulmin (1988), set out in their book *The Abuse of Casuistry*, the three sets of considerations that Aristotle put forward in his "Nicomanchean Ethics" to support his view that resolving moral problems does not call for appeals to theory but for phronesis, otherwise known as practical wisdom.

1.   In any field of argument we can look only for such kinds of exactitude or necessity as the nature of the case allows: and the practical nature of ethics makes it inappropriate to demand mathematical exactness or formal necessity.

2.   Given the concrete concerns of moral practice, ethics is never systematic in the way abstract theoretical disciplines such as geometry and planetary dynamics are.

3.   The moral claims that arise in practical situations depend on the detailed circumstances of individual cases, to such an extent that ethics rests on no invariable "axioms" or other strictly "universal" generalisations. (p. 281)

At this point, if one looks at the juxtaposition of the Sophists and Plato's early pragmatic non absolute thinking alongside the Pythagorean absolute certainty of mathematical formal deduction, it appears that the seeds of two very different strands of thought have been sown in the fertile intellectual soil of the ancient Greek culture. At this early stage in the history of ethical thinking, potential conditions have been created to allow movement back and forth between the two poles. A broader practical 'here and now' concrete approach to particular situations, known in Greek as phronesis, and a theoretical, atemporal, abstract approach based on the search for universal laws and the formulation of deductive principles known in Greek as episteme, (Jonsen & Toulmin, 1988). Apart from indicating that the abstract theoretical approach to ethics was not, even at this early stage, the only approach to ethics, this back and forth movement also demonstrates that attempting to reconcile theory and practice is by no means only a feature of modern times but has been grappled with for centuries.

There are two other groups of Greek thinkers whose original ideas have also had a formative influence down the corridor of time and appeared in more

recent ethical theories. Firstly, the Epicureans whose very important contribution was to identify the good with pleasure (Norman, 1995). Interestingly, the epicurean form of pleasure became unjustly associated with the hedonistic pursuit of sensuous pleasures, when in fact the real epicurean pleasure was a more austere form of mental tranquility to be achieved by rejecting determinism and freeing oneself of superstitious fears of the Gods and the after life (De Botton, 2000;Norman, 1995). The connection of the good with pleasure is seen again as a significant influence in the work of early utilitarians. Secondly, the Stoics developed the idea of the good life as "one lived in accordance with nature" or "the natural law". According to Norman (1995), this was to some extent present in the work of Plato and Aristotle but the Stoics combined living in accordance with nature with acting in accordance with reason, and by this reasoning rendering oneself immune to the disturbances of the emotions. There is some evidence here of a link with the abstract, distanced, and rational thinking found in the modern formal, deductive, and principle based approaches to ethics. The natural law approach is one that also been interpreted in many ways and other forms of ethical theories (Norman, 1995).

The demise of the intellectual and sophisticated Greco-Roman era and the rise of Christian religion brought about another significant phase in ethics. In the thirteenth century morality and religion were combined in medieval Christian ethics with St Augustine and Thomas Aquinas being the major influences in joining moral principles with divine commands (Jonsen & Toulmin, 1988; Norman, 1995). According to Norman (1995) Thomas Aquinas used Aristotle's account of natural human functioning, which he interpreted as a purpose that humans are endowed with by a divine creator. According to Capra (1982) this combination of Aristotle's system of nature with Christian theology established a conceptual framework of the world as "The notion of an organic living and spiritual universe" (p.38). The focus was on the body and soul, a dual concept involving the here and now of the problems and privations of practical daily life juxtaposed with the promise of the souls release after death to the eternal

spiritual beauty and happiness of heaven. Although the fit between the Aristotelian ethics and divine commands was not a comfortable one and contained many weaknesses, such was the power of religion that this conceptual framework remained largely unchallenged up until the sixteenth century (Capra, 1982).

In general, religious ethics and theology used a practical case by case approach to dealing with ethical problems and transgressions of canon law. One particular form known as casuistry, although lost through abuse and disrepute by the seventeenth century, has, as with Aristotle's virtue ethics, undergone a contemporary secular revival in contemporary bioethics (Jonsen & Toulmin, 1988). This will be covered in depth later in this chapter, and in Chapter Six. Religion and ethics, despite a tug-of-war between rational certainty and simple faith, have had a considerable continuing relationship that is still a valid and significant influence for many people today. However, according to Norman (1995) in the modern era the mainstream tradition of moral philosophy has been essentially a secular one.

It was between the sixteenth and seventeenth century that the fierce grip of religious doctrine began to lose strength against the rise of the new scientific approach, though not without a fight. The works of Copernicus, Kepler, Galileo and Descartes especially, presented significant challenges to the authority of the church (Capra, 1982). Galileo was actually imprisoned for expressing his radical and heretical ideas of the heliocentric organisation of the solar system, and on hearing of Galileo's treatment, Descartes quietly withdrew his work "the World", a treatise on physics and cosmology, as he also supported Galileo's hypothesis (Cottingham, 1995). After several years of discretion Descartes again began writing and publishing again producing an extremely influential body of work that has left him "usually regarded as the founder of modern philosophy" (Capra, 1982, p.41). Descartes book "Discourse on the Method of Rightly

Conducting One's Reason and Searching the Truth in the Sciences ", although regarded as a great philosophical classic, was according to Capra (1982), originally intended "not to teach philosophy but to serve as an introduction to science" (p.43).

Indeed the influence of Descartes method of thought and perspective of nature produced a whole new worldview that has influenced all branches of modern science right up to the present day, where it is still seen as useful provided its limitations are clearly recognized (Capra, 1982; Cottingham, 1995). Descartes is responsible for the idea of absolute certainty of scientific knowledge, a notion that echoes all the way back to Pythagoras, and the theory of the mind and matter/body separation resulting in the dualities of mind/body, reason/emotion, objective/subjective which throughout both science and medicine have had such a pervasive influence on our ideas of health, right and wrong, and human life in general (Capra, 1982; Cottingham, 1995). Also having direct and profound influence according to Capra (1982) was Descartes' view of nature as a perfect machine governed by mathematical laws, in which he shared Francis Bacon's view that the aim of science was the domination and control of nature, although Bacon's approach was empirical and inductive whereas Descartes was rational and deductive. The biomedical model developed from Descartes' powerfully influential mechanistic view of the world where, in the biomedical view, the human body is seen as a machine that could be understood by breaking it down into its constituent parts, which if defective could then be mended and reassembled (Capra, 1982).

What this enormously critical period appears to indicate is the intimate relations of influence between a paradigm, which I define in this study as a general worldview, and philosophy, ethics, science, and medicine. In this particular case it is the way that philosophy, ethics, science, and medicine bring with them an intensely compounded application of Cartesian thinking through

the joining of Cartesian influenced philosophy and ethics with Cartesian influenced science and medicine, all converging when brought together in the establishment of the field of bioethics. The ethical legacy of such a convergence is, the strongly held assumed superiority of the rational controllable intellect over the irrational uncontrollable senses, feelings and emotions, particularly when it comes to ethical decisions made in a world seen as comprised of individual parts that may be separated without consequence (Capra, 1982).

During the seventeenth and eighteenth centuries according to Norman (1995), a form of ethical naturalism reappeared in the works of the British moralists. Hobbes, seen more as a political philosopher than a moral philosopher, together with Hume, Bentham, and James Mill provided the return of another significant secular version of morality. These moral philosophers were looking again to nature and Man's *natural inclinations* (my italics) for the source of moral beliefs, but independent of any religious framework. They attempted to answer the following two major questions. Firstly, is morality grounded in self-love or benevolence? Secondly, are moral judgements the product of reason or sentiment (Norman, 1995)? As Norman (1995) points out, it was the work of Hume, Bentham, and James Mill who in answer to these questions laid the foundations of the ethical theory of utilitarianism. The utilitarians went so far as to create a measurement tool of units of pleasure (hedons) to more accurately determine the maximization of pleasure or happiness over displeasure or unhappiness. The focus of this central principle in utilitarianism aligns pleasure or happiness with "the good" which links back to the original epicurean influence of equating what is good with happiness or pleasure as mentioned previously. Utilitarianism was further refined and modified by John Stuart Mill and has continued to be modified by other utilitarian philosophers who have stamped their influence on the development of this ethical theory.

In the nineteenth century according to Jonsen & Toulmin (1988), moral philosophy and law writers moved away from the variety and discrimination of the practical situation and case method, toward universal systematic theories of ethics providing yet a further significant example of the back and forth movement between practical and theoretical approaches. In the 1860's the noted philospher Henry Sidgwick, became convinced "that moral philosophers should rise above the level of specific practical cases, and engage in a critical debate about more general or "fundamental" principles." (Jonsen & Toulmin, 1988, p. 280). Following this and in response to the development of utilitarianism and ethical naturalism, Immanuel Kant put forward his ethical theory of deontology or duty, and formulated his categorical imperative that "one must act in such a way that one can will the maxim of ones actions to be a universal law" (Norman, 1995, p. 589). Kant proposed in opposition to utilitarianism, the idea that morality lay not simply in the consequences but in "the motivation to perform ones duty simply for its own sake" and that one must "treat all persons never merely as means to an end, but always also as ends in themselves" (Norman, 1995, p.589). According to (Norman, 1995), the resulting theoretical ethical arguments and inquiries dominated English debate till after World War II, and eventually both the USA and Britain followed the lead of Sidgwick firmly in the realms of the theoretical approach.

History of Contemporary Bioethics World War II- 1970's

Bioethics did not materialise out of a vacuum. In the aftermath of the Second World War several major social and scientific events began to create the broad underlying changes that eventually lead to the formation of bioethics (Jonsen & Toulmin, 1988). Through the media public understanding not only of the sheer mass destruction of human lives but also the manner in which they were lost, for example the revelations of the Nuremberg trials, and the profound sequelae of the bombing of Hiroshima, created a new climate of questioning and surfacing of doubts (Gillon, 1998; Johnstone, 1999; Jonsen & Toulmin, 1988;

Tong, 1993). At the same time the scientific discovery of the structure of DNA began to open up an entirely new realm of potential and possibilities in biology and medicine (Weiss, 1995). As a result of these formative scientific and technological advancements together with the social changes many long held values were held up to scrutiny in the open discussions, dissent, and media coverage of the radical 1960's.

Most of the early scientific advances were in the realms of biological medicine and were implemented in healthcare, which in turn created a challenge to established practices in medicine and many of it's underlying assumptions (Gillon, 1998; Pellegrino, 1993; Weiss, 1995). One of the first new technical advances was the ability to successfully transplant a human heart. However, situations developed that had serious ethical implications and consequences not previously encountered that concerned the health professionals, the lives of the patients, their families and the communities they came from. Issues arose surrounding establishing the criteria for what constituted brain death, and when or whether to approach grieving relatives regarding organ donation from their deceased family members. Further new scientific technologies followed in fairly rapid succession adding more challenges.

According to Jonsen and Toulmin (1988) this flurry of activity extended to philosophical ethics directing the attention of philosophers to medicine and medical ethics where "it seemed to philosophers that here was a field in which the practical merits of their theories might at last be tested" (p. 305). At the same time, according to Pellegrino (1993) physicians turned to the philosophers who were beginning to write and speak on medical ethical issues as they appeared to offer a systematic and relatively objective way to approach their increasingly complex ethical problems.

At this point we have the coming together of two centuries old traditions, philosophical ethics and medical ethics. They originate from separate sources, ancient Greek philosophy for philosophical ethics and ancient Greek medicine for medical ethics. The sources of philosophical ethics (moral philosophy) has already been covered. The source of medical ethics rises from the same wellspring in the Hellenic era but from a different body of work known as the Hippocratic corpus (Pellegrino, 1993; Weiss, 1995). According to Pellegrino (1993) "the ethics of the corpus are a mosaic of moral precepts written at different times and influenced by most of the major schools of ancient Greek philosophy" (p. 1159). These ethical precepts covered for example, beneficence, nonmaleficence, confidentiality, prohibitions against abortion, euthanasia, and sexual relationships with patients, as well as requiring the physician to lead a pure and virtuous life, and of course it contains the Hippocratic oath (Pellegrino, 1993). As Pellegrino further explains,

> *…the ethics of the physician patient relationship, the fulcrum on which the decisions of the physician and the well-being of patient balance, was not systematically justified or derived in any formal way … and even the physicians who were philosophers said little about the ethics of the profession in which they were trained (Pellegrino, 1993, p.1159)*

Therefore although Greek medicine was intimately associated with Greek philosophy during their long histories, the philosophical gaze was never turned in a direct critical manner on medical ethics, even in its earliest Hippocratic beginnings.

Thus as well as inheriting a double dose of Cartesianism the formation of bioethics also entailed the joining of philosophical ethics with medical ethics, two previously separate independent and proud historical traditions. The physician, with the backing of the Hippocratic oath, had maintained the

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powerful sole charge paternalistic position within the sacrosanct relationship between Physician and patient, and until this point had successfully avoided any external attempts at power sharing as Weiss (1995) notes

> *The Hippocratic oath reflects the traditional notions of paternalism of the medical profession, which regard the physician as the primary decision maker for the patient and the best person be able to decide what course of action is in the patient's best interest (p. 86).*

Jonsen and Toulmin (1988) support Weiss emphasising that, over time "The medical profession had slowly achieved a moral pre-eminence that almost ruled out debate about medical ethics" (p.304). At the time it was a significant factor leading to difficult adjustments in the initial relationship between philosophical ethics and medical ethics. Although it is somewhat less obvious today there is still evidence of mutual discomfort and the continuing existence of separate cultures that meet but rarely blend well if at all particularly in areas such as clinical ethics (Jonsen & Toulmin, 1988; Levi 1994; Pellegrino, 1993; Reichlin, 1994; Turner, 1998).

Another source of irritation between the initial partners was that the Hippocratic tradition of the medical profession had remained relatively constant and stable for centuries, whereas, as has been demonstrated previously in this section, philosophy and ethics had been subject to regular upheaval and change over time. Despite the immediate pressing need for assistance with new complex ethical situations the struggling physicians were concerned about the effect of this volatility being introduced within their profession. This concern is reflected in the comment by Pellegrino (1993) that,

Medical ethics is too ancient and too essential a reality in the lives of physicians, patients, and society to be left entirely to the fortuitous currents of philosophical fashion, or the unsupported assertions of clinicians. (p.1162)

Within the newly formed bioethics it soon became apparent that applying the variants of act or rule-based deontology or consequentialism from philosophical ethics was rather cumbersome (Jonsen & Toulmin, 1988). Few apart from philosophically trained bioethicists had the background or training to use them adequately. Physicians' medical expertise "…does not automatically equate with ethical authority or rectitude" (Pellegrino, 1993, p. 1158). Adjustments and changes had to be made and according to Pellegrino (1993) in a relatively short time the theory of prima facie principles developed by Ross was most effectively adapted to medical ethics by Tom L. Beauchamp and James F. Childress in their book "Principles of Biomedical Ethics", and soon became the dominant way of doing ethics. As Pellegrino further points out, two of the principles, beneficence and nonmaleficence, were familiar to the physicians and were readily accepted, the other two principles autonomy and justice were not familiar and "seemed in some sense antithetical to the traditional medical ethic"(p.1160). The principle of autonomy directly contradicted the traditional authoritarianism and paternalism of the Hippocratic ethic and physicians have had the greatest problems with this principle as it was often erroneously interpreted is being in opposition to beneficence (Pellegrino, 1993). According to Weiss (1995) even for modern physicians there is an inherent tension at the core of bioethics between:

…the need to balance the right of the patient to act in his or her own best interest without constraint from others (autonomy) and the obligation of the healthcare professional to act to promote the ultimate good of the patient, prevent harm, or supplant harm (beneficence). (p.86)

Physicians have become more accepting of the principle of autonomy largely because it is consistent with the powerful contemporary societal focus on individualism, privacy and self-determination, and it is central to informed consent (Pellegrino, 1993). Weiss (1995) provides further evidence of this acceptance as he points out that in the USA "The President's Commission for the study of ethical problems in medicine and biomedical research (1983) declared that where a conflict between a patient's self-interest and wellbeing remains unresolved, respect for autonomy becomes paramount." (p.86). Incidentally it was this same President's commission in which Jonsen and Toulmin (1988) took part, prompting their work devoted to the rehabilitation of the casuistic or case approach to ethics.

Of the four principles justice was the most remote from traditional medical ethics, and despite its prominence in the philosophies of Plato and Aristotle justice received no specific attention from a Hippocratic ethic that centred on the welfare of individual patients and not of society (Pellegrino, 1993). Once again, in recent years, justice has been accepted into medical ethics (and bioethics) due to increasing disparities in the distribution of health care and, according to Pellegrino (1993) the possibility "that physicians may become agents primarily of fiscal or social purposes rather than that of the patient" (p.1160). It was John Rawls' sophisticated contractarian theory of justice and his hierarchical ordering of obligations and principles relative to distributive justice that placed justice clearly the forefront of bioethics (Pellegrino, 1993; Norman, 1995).

Summary

An understanding of the historical relationship between philosophical ethics and medical ethics is fundamental to understanding much of what is happening in bioethics today. However, bioethics is far from consisting of that relationship alone. Health care is being delivered by an increasing number of different health care professionals involving a wide diversity of views, ethical systems,

practice methods, and multiple healthcare settings (Johnstone, 1999; Reich, 1978). This means that there can be a greater number of different views held in situations requiring decision making about a person's healthcare, not least including the views held by the person in question (Levi, 1994; Johnstone, 1999; Turner, 1998). The ethical aspects of the issues raised by the new scientific technologies have been taken from the esoteric world of philosophical ethics into the broader public arena because at a practical level they concerned deeply held values of ordinary people. These values concern the issues of birth, life, and death that directly involve everyone at some point in their lifespan. The sensationalism of some of the issues naturally drew the involvement of various forms of the media, so that the ensuing broader discussions of war issues, abortion debates, the burgeoning feminist movement, and a focus on human rights created a strong challenge to the status quo (Weiss, 1995; Gillon, 1995). A flow on effect of this challenge was the growth and expansion of the consumer and patient rights movements, a generally better informed public, and greater recognition of the self determining nature of people to stand up for their perceived rights in healthcare (Weiss, 1995). Without doubt it was also another challenge to the inherent paternalism and power base of medicine. In the next chapter the focus turns to the current state of contemporary bioethics and a critical appraisal of its decision making approaches from the bioethical, feminist and nursing perspectives.

CONTEMPORARY BIOETHICS: A CRITICAL PORTRAIT FROM THE BIOETHICAL, NURSING, AND FEMINIST PERSPECTIVES

We should be on our guard not to overestimate science and scientific methods when it is a question of human problems. (Albert Einstein).

Introduction

This chapter continues the focus from chapter four on bioethics as the subject, but is concerned with outlining and critiquing the current form of contemporary bioethics. This includes outlining the most significant continuing features, along with the most significant changes that have developed. This is followed by a critical appraisal of the field of contemporary bioethics, and particularly of the proposed alternatives to principle based approach to ethical decision-making, from the bioethical, feminist and nursing perspectives.

Contemporary Bioethics

The most significant overall continuing feature of contemporary bioethics according to Gillon (1998) is its constant growth and expansion. Gillon goes on to say that this growth is general, occurring across the full range of areas and substantive issues covered in bioethics, including the number and range of disciplinary and other contributors, and the proliferation of different approaches proposed for addressing the issues. It is a direct response to the pressure of persistent new developments in science and technology, and their inevitable consequential impacts on the lives and health of individuals and communities, and those persons who in turn care for them. Thus the boundaries of bioethics continue to expand and remain fluid, as technologies bring cutting edge developments virtually piling on top of one another. The

genetic cloning of "Dolly" the sheep, for example, was a significant milestone that has now been rapidly surpassed by the genetic engineering of human tissues, and potentially whole organs from undifferentiated embryonic stem cells (Coghlan, 2000).

The exact list of areas of ethical enquiry covered by bioethics now still remains in dispute depending on the varying perspectives held regarding the boundaries between bioethics and applied ethics. However, the following far from exhaustive list of areas according to Gillon (1998) includes the healthcare relationship, patients interests and the interests of others, conceptual analysis, life and death, distributive justice, research and experimentation, the relationship between science technology and society, and here Gillon includes environmental ethics as part of bioethics when, as we have seen previously, more recently environmental ethics has been given its own place in the broader category of applied ethics (Winkler, 1998). It is possible, I believe, to see that there could be macro and micro levels of situations in environmental ethics that would make it acceptable for them to belong in either bioethics or the broader category of applied ethics. An example of the micro level that would be appropriate under bioethics could be an individual with asbestos poisoning requiring healthcare treatment. An example of the macro level could be an oil tanker spillage at sea.

According to Gillon (1998) all of the areas of bioethics previously listed have multiple sub categories with the range now becoming so large and unwieldy that as Gillon explains, some have advocated that it should be split into subdivisions of:

> 1. *Theoretical bioethics, concerned with the intellectual foundations of bioethics.*

2. *Clinical bioethics, concerned with ethical issues arising from interactions between patients and those who care for their health.*

3. *Regulatory and policy bioethics, concerned with rules, regulations, and laws in the context of bioethics.*

4. *Cultural bioethics, which seeks 'systematically to relate bioethics to the historical, ideological, cultural and social context in which it is expressed. (D. Callahan, 1995)'. (Gillon, 1998, p. 310)*

This further serves to illustrate the potential for fluidity in the boundaries of contemporary bioethics. Some find the inability to establish finite boundaries in contemporary bioethics a fruitless pursuit for definition ending in frustration, however, Gillon (1998) proposes that it should be seen in a more positive light as an indication of the dynamic complexity of a rapidly growing field in need of some continuing flexibility as it continues to grow.

Bioethics and the Law

One of the results of this rapid expansion especially in the area of cutting edge technology is that bioethics is finding itself forging closer connections with the law. The nature and potential impact on human society of some of these technologies is of such significance that in response there has been a perceived need for decisions regarding these bioethical issues to be translated into protective legislation made at a national level (Weiss, 1998). Although these ethical and legal processes are usually slow and deliberative, some definitive ethical decisions have already been made regarding specific technologies, for example the legislation passed in the USA preventing use of genetic engineering technology for cloning human beings (Weiss, 1998).

More frequently in contemporary bioethics, bioethicists, ethics committees, and other bioethics "experts" are being brought in as consultants in a range of legal

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cases concerning contested ethical decisions in healthcare situations that seek resolution in local and regional court systems (Kopleman, 1998). For example, here in New Zealand the Rau Williams case, which concerned withholding kidney dialysis because of the person's age and stage of dementia. (Ventnor as cited in Woods, 1997). Fundamentally this was concerned with the volatile area of rationing healthcare resources. Other more recent examples are in the cases where families have opted out of orthodox oncology treatment for their child's cancer to pursue a range of alternative treatments. Fundamentally this concerns issues of choice, options and rights, is the locus of control ultimately with the oncology experts, or with the parents, and at what point are the child's wishes considered. If this point is age dependent who decides and where is the age line drawn.

Ethical norms are distinct from legal law, and need to be that way as there are instances where what is legal is not necessarily moral and what is considered moral is not necessarily legal (Johnstone, 1994). Ethics is vitally important as an independent value system that can be used to judge the moral acceptability or unacceptability of a valid legal law (Beauchamp & Childress, 1989; Johnstone, 1994). However, common sense would also dictate that this does not preclude them joining forces and working together in a mutually supportive manner where there is both agreement and need. There are differing views among bioethicists as to whether and under what conditions this can and should happen. Sharpe and Pellegrino (1997) argue that the courts have often "viewed ethics testimony as authoritative in determining right and wrong." (p. 374). They go on to explain that in their view this is can be dangerous in that "the assumption that there can be normative experts is, at best, dubious in a morally polyglot society."(p.374). Further to this Sharpe and Pelligrino (1997) point out that in cases of adversarial litigation questions are raised about "the integrity of the ethics experts' pedagogical role - that is, their descriptive and analytical expertise - when they are retained to serve one of the disputants" (P. 374).

In general, regarding the issue of bioethicists' testimony in the courts, Sharpe and Pellegrino (1997) hold that the role of the court is to resolve legal, not moral disputes, however they also see that, "…matters of morality, when they are used to underpin law, should be argued as widely and openly as possible, when a law is being framed and not in the narrower arena of a court proceeding." (1997, p. 379). From an alternative view Morreim (1997) points out that although it "may be quite right that in a secular pluralist society no particular group can establish claim to intrinsic moral superiority, this need not imply that courts should rule on major moral issues in a vacuum" (p. 295). He concludes that "there seems to be fairly persuasive reason to believe that moral values can not be excluded from legal decisions at least some of the time, and that people trained in (bio)ethics might be able to enrich the proceedings." (p. 295).

One area where it is critically important to understand the difference between the legal and ethical/bioethical aspects of an issue is in the area of concrete clinical practice in the healthcare arena. Here at the practical level involving the daily lives of vulnerable persons, distinguishing between moral rights and legal rights and the different ways they can be and are enforced is essential (Johnstone, 1994) The significance of this aspect of practice has been underrated as evidenced by the fact that it was only as recently as 1998 that a group of teachers from medical schools in the UK produced a core curriculum model for teaching medical ethics and law as an integrated subject to medical students (Doyle & Gillon, 1998). The nature of the interface between the legal and the ethical in the healthcare arena is a part of the complexity of bioethics and one that would seem to warrant more attention not just within medicine. Healthcare delivery is multidisciplinary, and includes many other providers including nursing, and other orthodox and non-orthodox healthcare professionals besides medicine (Johnstone, 1994, 1999).

Bioethics as a multidisciplinary discipline

The increasing collaboration between bioethics and law may be of note given their different orientations and somewhat traditional suspicious regard for each other (Sharpe & Pellegrino, 1997). However, the collaboration of different disciplines within bioethics is not a novelty. Bioethics, began by bringing together the previously distinct disciplines of moral philosophy and medical ethics, to which the contributions of many more disciplines such as biology, and the humanities including nursing, sociology, and others have since been added. Thus the multidisciplinary nature of bioethics has become one of its characteristic contemporary features (Reichlin, 1994; Weiss, 1998).

Gillon (1998), notes that the multidisciplinary nature of bioethics was supported and perpetuated from the beginning of bioethics in the USA in the early seventies with the establishment of a range of centres for the multidisciplinary study of bioethics established either as parts of universities and as private institutes. He notes for example that The Institute of Society Ethics and the Life Sciences, which later became the Hastings Centre, and the Kennedy Institute are two prominent examples of multidisciplinary academic and teaching centres of bioethics. According to Kopelman (1998) in 1998 three such centres, the American Association of Bioethics, Society for Bioethics consultation, and the Society for Bioethics and Humanities were united into the American Society for Bioethics and Humanities. While acknowledging the multidisciplinary nature of this organisation, Kopelman (1998), argues that bioethics and humanities can in fact be considered one field, in this case because they are bound together by their joint commitment to six activities in which all members

1. *Work on a set of defining problems about the human condition, many of which are momentous and urgent*

2. *Use interdisciplinary approaches to solve them*

3. *Employ cases and practical reasoning to understand problems and reach answers*

4. *Apply "Dewsonian" teaching methods and goals to make students better problem solvers*

5. *Find morally justifiable solutions*

6. *Seek interdisciplinary and collaborative scholarship, service or teaching (p. 358).*

Kopelman (1998) goes on to say that these multidisciplinary centres of bioethics are also sources, in the USA, for the development of the ethical advisory and consultant role as she explains, "Leaders in our field (bioethics and humanities) are put on commissions to advise elected officials in state and federal agencies about how to set social policy" (p.354). The advisory role also extends to research related policy and the legal domain as previously discussed in this chapter. The advisory and consultant role is another relatively new and fast growing area in contemporary bioethics in which hospital ethics committees and independent ethics consultants are also a significant part.

However the label "expert" and " leader in the field" need to be treated with some caution. It is a possibility that predominantly, only those with academic or classical philosophy education backgrounds are going to be deemed "experts". However, possession of these credentials does not automatically mean one is more entitled to make or pass judgement on ethical decisions, or solve ethical situations, than people with other kinds of qualifications and experience. For example Winkler (1998) states "…a more contextualist approach to the process of moral reasoning will recognise a central role in moral discourse for a variety of skills and intellectual, imaginative, and emotional resources beyond those that are typical of the moral philosopher" (p.196). A further point to note is that given the breadth of the field of bioethics it would be difficult to become expert in all areas, and thus it would make sense if a consultant were deemed necessary to select a person with experience in the particular area required.

Plurality and the post modern perspective: Bioethics and the growth of uncertainty

The most significant change between the early bioethics and contemporary bioethics is according to Johnstone (1999), "the demise of traditional moral certainty" (p.2). It is the major factor providing the contemporary context for bioethics as a whole, and has contributed largely to the development of a pluralistic worldview, as mentioned by Sharpe and Pellegrino (1997), and Morreim (1997) previously. According to Anderson as cited in Johnstone (1999),"There is increasing recognition that our moral standards are not absolute, but are ever changing social creations" (p.2). In noting the emergence and changes in ethical theories over time, as outlined in the history of bioethics section, it appears there is some evidence in the historical progression of changes of our many moral theories and standards, indicating that they have always been 'ever changing social creations'. This has gone unrecognised for so long, possibly because in those earlier times it was still thought that, outside of our social embeddedness, in the realms of abstract moral philosophy, there was an undefined but continuing exploratory developmental process occurring in which the definitive universal moral theory was *about to be* discovered. Thomas Khun has a similar explanation used in regard to scientists trying to identify the universal theory for science, without having developed a clear, definitive, criteria. He states that:

> *…few philosophers,(of science) if any, have claimed to possess either a complete or an entirely well articulated list of criteria. For some time, therefore, they could reasonably expect that further research would eliminate residual imperfections and produce an algorithm able to dictate rational unanimous choice. (Khun, 1999, p.37)*

In all of the centuries of philosophical and ethical endeavour the quest for the definitive universal moral theory has never been satisfactorily fulfilled (Tong,

1993), and neither has the one definitive scientific theory eventuated as yet. What we have are many different theories scientific and moral, some of which are in direct conflict with each other. Although a pluralistic morality and a postmodernist perspective, are far from unanimously accepted, as a valid approach, their presence is increasingly evident as Englehardt (1996) states "Moral diversity is real" (p.3), and it is supported by many contributors to bioethics, particularly in clinical ethics. See the works of (Johnstone, 1999; Komesaroff, 1996; Levi, 1994; Reichlin, 1994; Turner, 1998). With the lack of certainty and increased recognition that there is no one reality but multiple realities, leading to a plural world and a plurality of ethical perspectives, what are we left with? How is one to make effective decisions in ethical situations?

According to MacIntyre (1984), and Jonsen & Toulmin (1988) many fear the assumed anarchy and chaos of total relativism with no common ground for any systematic approach to address ethical situations. However, the appearance of postmodern characteristics in bioethics need not be a signal for panic or a slide into extremes of relativism. In today's contemporary bioethics as Johnstone (1999) has so clearly pointed out, one is certainly confronted with, less certainty, less rigidity, more ambiguity, and more possibilities. She further points out, requires of us that,

1. *We 'need to think better and harder' about the issues in question (Boyle 1994)*

2. *We need to remember that the moral indiscernability, uncertainty, controversy and disagreement can and do have many causes, both practical and theoretical, (McCullough 1995); and*

3. *We need to accept that addressing moral problems in a sound and effective manner requires an appeal to a moral schema that recognises a multiplicity of possible solutions to a given problem, and that a moral schema which insists on the being just one single correct answer to a given moral problem may compound rather than remedy that problem (Johnstone, 1999, p.5).*

These are not unattainable goals, and in working towards them opportunities may be created, where we may be more likely to move towards achieving "tolerable and peaceable bonds between people" (Englehardt, 1996). It is essential that in doing this, it is recognised that the terms tolerable and tolerance have limits of acceptability (Held, 1995). A lack of sensitivity and awareness of the limits can lead to tolerance becoming indifference, neglect, and abuse resulting in real harm to a person (Johnstone, 1999). Examples of this are seen in elder, child, and partner abuse (Carse, 1996; Held, 1995; Wilson, 2000).

The presence of uncertainty indicates the requirement for a commitment, to be willing to devote attention, to listen and be open, to participate (these matters are not only the concern of bioethicists and physicians). According to Tsouyopoulos (1994) " Post-industrial society has turned our world of electronics into a world of information and communication. This also implies new strategies of understanding one another… For in a communicative society, listening is central and obligatory." (p.271). She goes on to elaborate that in medicine the worlds of the physician and the patient are deeply different, what is relevant to the physician engaged in the world of science and technical progress may be quite irrelevant to the patient. One way of helping the patient in his or her human condition, while still supporting medicine where it is most effective, is according to Tsouyopoulos (1994), by demystification of medical research and better information for patients. Tsouyopoulos claims that "Postmodernity tries to understand the world of both physician and patient by respecting the difference between them" (p.271), and that in doing so "post modernity has gained the "right" to be always informed about every step of the promised progress of scientific medicine. In concluding Tsouyopoulos (1994) states that "Postmodern society regains the right to refuse faith in prophecies that do not obtain credibility through information" (p.271).

The influence of the postmodern perspective is bringing about some radical changes in bioethics, and change though inevitable is not well accepted by all. However uncertainty and degrees of relativity need not mean the realisation of the Nietzschean vision of only being able to discuss multiple truths from totally incommensurate perspectives. According to Agazzi as cited in Reichlin, (1994) there should be discussion and assessment of the plurality of views and approaches, and it should aim to be " the building of an authentic ethos, resulting from a thought out collective agreement on a constellation of values seriously and responsibly assumed" (p. 87). According to Tsyouypoulos (1994) the postmodern perspective allows for a dialectical relationship between the modern and the post modern in which the two positions may comment upon and expand or change each other, without the super-session of both into one "homogenised" synthesis (p.268). In sum it would appear that with the advent of a plural and postmodern world, coming to terms with accepting uncertainty, ambiguity and complexity in bioethics is somewhat inevitable. Becoming informed and choosing a direction is one approach, much like a skilled archer we need to take aim, it does not necessarily mean that we will get the bulls eye (the ideal) but we have a much better chance of getting nearer to it than if we do not aim and fire at random (adapted from Aristotle as cited in Gadamer, 1986, p.163). Another positive approach to dealing with the changes as Johnstone (1999) explains, is to put effort into finding the things that do connect us and bind us together as human beings so that our multiple realities don't become increasingly isolated fragments.

To explore some of the changes in contemporary bioethics in more detail, it is helpful to examine current debates regarding some of the proposed alternative ways for approaching ethical decision-making. Therefore the remainder of this chapter presents outlines and critiques of these approaches from the bioethical, the nursing and the feminist perspectives respectively.

Critique of contemporary bioethics from a bioethical perspective

The major internal focus preoccupying the field of contemporary bioethics is the debate surrounding which particular method or combination of methods is best suited for bioethical deliberation and decision making in ethical situations. (Jonsen & Toulmin, 1988; Levi, 1994; Pellegrino, 1993,1995; Thomasma, 1994; Turner, 1998). Within a short time after philosophical ethics was introduced into medical ethics, the principles of autonomy, beneficence, non maleficence, and justice were formulated and adopted as the bioethical principles (Pellegrino, 1993). Almost immediately, some medical practitioners began to raise questions about the appropriateness of the fit between the abstract impartial principles and the kinds of complex, real life events encountered in clinical practice (Jonsen & Toulmin 1988; Pellegrino, 1993; Pellegrino & Thomasma, 1994). This questioning has become more prevalent and wide-spread developing into a persistent critical debate (Reichlin, 1994). This has become clearly evident in the many journal articles and books containing contemporary bioethical discourses examined in the course of developing this study.

Bioethicists and physician critics of the principle-based approach identify the main problems with the use of the ethical principles to be, that they are too often in conflict with each other in a particular situation with no definitive means of ranking the order of importance (Jonsen & Toulmin, 1988). Abstract principles are inadequate for attending to the complex particularities such as the unique narratives of each participant (Dubose & Hamel, 1995), or for including cultural differences (Turner, 1998), and the practicalities of everyday clinical practice involving the realities and minutae of people's lives (Komesaroff, 1996; Seedhouse, 1995). This dissatisfaction produced a search for a solution that has in turn, resulted in the proposal of several different approaches to ethical decision making, either as alternatives or supplements to

the traditional bioethical principles (Pellegrino, 1993). The main approaches proposed are, a revival of casuistry and virtue ethics, and the development of the newer approaches of hermeneutical ethics, narrative ethics, and the ethics of care. Each of these proposed candidates are discussed below.

Casuistry

One of the first alternatives proposed to remedy the perceived inadequacies of the purely principle-based approach was casuistry, a revival of a very old method of deliberation and decision making. The original form of casuistry existed between the fourteenth and seventeenth centuries, as a form of reasoning and justification practiced by theologians and canon lawyers (Jonsen & Toulmin, 1988). This form of reasoning and justification was developed to establish whether an act that an agent wishes to perform does or does not conflict with a law. It is noteworthy that this form of casuistry developed at a time when law and morality were generally considered as one and the same, and they shared a much more intimate relationship than they do in the present. Jesuit priests in particular became renowned for developing casuistry into the art of resolving problems of moral conscience, with the starting point being the individual case which is then weighed against other similar cases (Jonsen & Toulmin, 1988). However, eventually the casuists' skill in making increasingly fine distinctions began to be used to justify acts in such a way that they did not appear to conflict with a law, when often they were clearly in conflict. Such justifications were regarded as pandering to the vice of laxity, and under severe criticism and pressure from the church casuistry was discredited and it declined, virtually disappearing (Jonsen & Toulmin, 1988).

The recent revival of casuistry, credited to Jonsen (1986) and Jonsen and Toulmin (1988) in their book *The Abuse of casuistry,* has emerged as a definite alternative to the hegemony of the principle based method of moral analysis

(Arras, 1991). According to Strong the general features of modern casuistry are that,

> *…it is a case based approach in which an argument is developed by comparing the case at hand with paradigm cases in which it is reasonably clear what course of action should be taken... the comparisons of cases are made in terms of certain morally relevant factors, which can vary from case to case. The decision that is best will depend on the extent to which these factors are present in the given case... casuistry does not generally claim to reach certainty in its conclusions. The strength of the conclusions depends on the plausibility of the comparisons with paradigms cases (p.396).*

In casuistic argumentation, Strong adds, there is room for disagreements concerning a number of matters, such as whether a case is more similar to one paradigm or another, and whether the morally relevant factors are present in a case to sufficient degree to warrant a given conclusion. (p.396). The new casuistry is an inductive method that works from the bottom up, emphasising practical problem solving by means of nuanced interpretations of individual cases (Arras, 1991).

In this view casuistry appears to demonstrate a connection with Aristotle's practical approach to ethics and the importance and necessity of experience in developing practice wisdom. Both Jonsen and Toulmin (1988, p.40), and Kuczewski (1994, p.99) recognise practical wisdom or prudence as a kind of pattern recognition that demands experience with particulars. In the use of this terminology it is possible to see here a connection with Benner's (1984) research outlined in Chapter Three where she discusses the development of practice wisdom through practical experience, and pattern recognition in nurses' caring practices, and in the development of nurses' ethical comportment (Benner, 1991). On the other hand casuistry has not been overlooked in nursing, and has

been investigated as an ethical approach for use in the discipline of nursing. See the work of Gaul (1995), and Dimmitt and Artnak 1994).

Criticisms from within bioethics against casuistry come from four main points. Firstly according to Wildes (1993) casuistry is only possible if there is a commonly agreed upon morality. He explains that casuistry came from a time in the 15th and 16th century when Roman Catholic moral theology provided a common morality that served as the context of casuistry. By contrast, contemporary secular society is characterised by a plurality of moral viewpoints. Secondly, according to Arras (1991) because casuistry takes intuitions about cases as a given, it is not able to examine those intuitions critically. He points out therefore, that casuistry cannot challenge established social views or the values such as the male dominated medical profession.

Thirdly Arras (1991) states that "for all of the emphasis upon the interpretation of particular cases, casuists have not said much, if anything, about how to select problems for moral interpretation... practitioners may be bound to conventional ways of thinking and of conceiving problems that tend to filter out other equally valid experiences and problems." (p.38-39). According to Warren, as cited in a Arras (1991) "As a result, a whole range of important ethical problems-including the unequal treatment of women in health care settings, sexist occupational roles, personal relationships, and strategies of avoiding crisis situations-have been either downplayed or ignored completely."(p. 39). Finally, Arras (1991) who stands out remarkably among bioethicists as being notably aware of the feminist and nursing positions, points out the consequences of the relative neglect of alternative perspectives held by other participants is that,

Quite often, we get the attending's (or the house officer's) point of view on what constitutes 'the case', while missing out on the perspectives of nurses, and social

workers and others. Since most cases are complicated and enriched by such alternative medical, psychological and social interpretations, our casuistical analyses will remain incomplete without them (p.39).

Although casuistry has drawn much criticism from within bioethics, according to Jonsen and Toulmin (1988), Arras (1991) and others, it still remains a valid alternative or at the least as a complement to the application of abstract impartial principles.

Virtue ethics

Virtue ethics has ancient origins stretching back even further than that of casuistry, to the genealogical roots of Western ethical thinking itself in the works of the Stoics, Plato and Aristotle. It suffered decline in Western philosophy but not extinction in the post-mediaevil, and post enlightenment periods, for a variety of reasons largely due to changes in religious and scientific thought right up to the present, where it is experiencing a revival (Pellegrino, 1995). Of particular note is the fact that virtue ethics is ubiquitous, it crosses cultural boundaries as Pellegrino (1995) points out "every culture has the notion of the virtuous person... these paradigm persons are celebrated in the second story's poetry and ritual of non Western and Western cultures" He goes on to say that the moral values and characteristics of the virtuous person is formalised in varying degrees in the works of Plato and Aristotle,as mentioned, and of "Confucius (Cua, 1978) and Lao Tse (Waley, 1956), Yearly, 1990), the Hindu concept of Dharma (Jhingran, 1989), and the humanism of African tribal cultures (Wiredu, 1992)." (Pellegrino, 1995, p. 255). A point of similarity can be seen here with the description of caring provided, at the beginning of Chapter Two.

The durability, and it could be assumed the ubiquity, of virtue ethics is attributed according to Pellegrino (1995) to the fact that "one cannot completely separate the character of a moral agent from his or her acts, the nature of those acts, the circumstances under which they outperformed, or the consequences." (p.254). Pellegrino explains that:

"Virtue theories focus on the agent; on his or her intentions, disposition is, and motives; and on the kind of person the moral agent becomes, wishes to become, or ought, as a result of has or her habitual disposition to Acton certain ways"(1995, p. 254).

He further emphasises that that these aspects of virtue are inseparable part of the moral life and any moral theory that ignores them fails to encompass the fullness and complexity of the challenge and struggle to be a good human being (1995, p. 254). In virtue ethics then, "the normative standard is the good person, the person upon whom one can rely on habitually to be good and to do good under all circumstances" (Pellegrino, 1995). However he points out that this leads to a problem of circular logic "that holds the right and the good to be what the virtuous person takes them to be while defining the virtuous person as the one who is and does what is right and good." (p.255). This in turn, as Johnstone, (1999) explains, leads to the "inability of virtue theories to explain adequately its force as a moral action guide (viz. Compared with other obligation based theories that can rely on the force of moral rules, principles and maxims to justify moral conduct)" (p.105).

As with most ethical approaches virtue theory is not without its difficulties. In Pellegrino's view another difficulty with virtue ethics is that the classical insistence on the virtues as excellences seems too much to ask of individuals in a legalistically shaped society where "The only duty is not to infringe on the liberty of others. Everything else is beyond duty (1995, p.263). However in the

view of Johnstone, (1999) the difficulties seen by Pellegrino may be "more a product of traditional modernist philosophical approach used to critically examine and raise objections to virtue theory, than a problem of virtue ethics itself." (p.106). She explains that

> *given the distinctive non-rational quality of the moral virtues, it seems odd to suggest that virtuous actions require 'justification' (how does one 'justify' and inclination to be kind toward another, or to be fair? how does one 'justify' an act of saintliness or heroism?); similarly, it seems odd to expect that virtue theory can be reduced to a set of justificatory rules, principles and maxims (noting that, what makes the virtues what they are is their spontaneous and unconditional expression beyond that otherwise required by rules principles and maxims) (Johnstone, 1999, p.106).*

Knowlden (1990) a nurse scholar makes the point that "An actor's report provides more than the observer's description, for the telling action is inseparable from thought. Reasons do not produce my actions, but are embodied in them" (p.90). Johnstone (1999) further suggests that "to 'justify' the virtues in a traditional rationalistic and reductionist sense is to do violence to them and to all they represent." (p.106). Finally, in Johnstone's view seeing the expectation of people to be decent and morally excellent human beings as too high an expectation is incongruous. She points out that, "Even in its most traditional sense morality is precisely about expecting people to strive to achieve the ideal of morally excellent conduct. Virtue ethics is no different in this regard " (Johnstone, 1999, P.106). However, she emphasises that the fact that even though in reality people may not achieve such an ideal this is no reason to abandon ethics generally and it is no reason to abandon virtue ethics and particular (1999, p.106).

Virtue ethics rather than an independent theory, is more commonly seen as a complement to other ethical approaches (Pellegrino, 1995). It has distinct possibilities in other fields of ethical inquiry not least in the field professional nursing ethics and in aspects of a feminist perspective on ethics, and will be considered in more depth in chapter six.

Narrative ethics

In bioethics, narrative ethics is a relative newcomer. However according to Tovey (1998) there is already a significant body of literature established on a range of issues relating to narrative ethics. This includes discussion of "the meaning(s) of the term itself; its relationship with phenomenology, and with Christian ethics; the relevance of postmodernist analysis; and, of course, its relationship with literature" (p.176). Tovey (1998) holds that the elements of narrative ethics are first, that personal narrative rather than a pre-identified framework are central to the analysis, second, this narrative holds centre stage in the decision making/dilemma resolution process. Third, the approach is all about the achievement of an understanding of the meanings of the situation for those involved, and fourth, there is the recognition that it is only through knowledge of the personal, cultural and social context that the most appropriate ethical solution can be reached (p.177).

As with casuistry, a narrative approach to ethical deliberation is not unanimously or uniformly accepted in bioethics. Murray (1997) points out that the relationship of 20th-century moral philosophy to narratives is one of ambivalence. He goes on to say philosophers that have an analytic bent are apt to have suspicion or contempt for the claim that narratives are important for morality. At the same time, many of those same philosophers use narratives in their own arguments. Therefore Murray (1997) explains,

"There is an undeniable intellectual tension, as well as a political struggle, between those who insist on the importance of narrative in morality, and those who want to focus on the defensibility of propositions as the core of moral thought" (p.44).

He goes on to say he suspects that this conflict is also a reflection of differences in sensibility and personal history. Narratives are not only significant in ethical aspects of medical practice. Gillon as cited in Tovey (1998) notes that evidence based medicine is increasingly directing research and practice and a randomised controlled trial remains dominant in the collation and definition of that evidence base. However, Tovey points out that the potential offered by qualitative methodologies, such as the use of narratives, in evidence based practice is also beginning to receive increasing attention. According to Gillon as cited in Tovey (1998) this increased attention is in the pursuit of a deeper understanding and a more appropriate practice that would foster the integration of the art of medicine and the science of medicine. (p. 177). This notion is similar to that discussed in the section on the nursing perspective of caring regarding broadening the scope of what kinds of evidence are to contribute to evidence-based nursing practice, as pointed out by Fawcett, Watson, Neuman, Hinton-Walker, and Fitzpatrick (2001).

However, despite the desire for 'deeper understanding and a more appropriate practice' in medicine, for Gillon as cited in Tovey, 1998) the acceptance of narrative in ethics is only partial. In his view individual stories "are insufficient for medical ethics… they need to be used as stimuli and bases for research and reflection leading to generalisable conclusions in philosophical medical ethics." (p.178). Gillon goes on to say that "stories are necessarily outside of the research process; they provide a preliminary stage in which research ideas are formulated, one which is followed by, but never forms a part of, scientific procedure." (Gillon as cited in Tovey, P.178). The persistent preference for the

scientific over other qualitative approaches is indicated in creating other difficulties for a narrative approach to ethics. Language is understandably critical in narrative ethics as nursing scholars Rogers and Niven (1999) clearly explain that in narrative ethics

It is those tales and chronicles, those stories which give meaning to that particular person's life. Inescapably, each narrative is unique. It is this quality of uniqueness which is the locus of narrative ethical enquiry. The focal point of ethical concern then becomes that narrative which is that person's particular definition of self. (p.95-96)

How each narrative is approached, that is, how it is handled or used, has the ability to alter that 'definition of self' From a nursing perspective of narrative ethics as outlined by Rogers and Niven (1999), the language used in philosophy, medicine and even in sociology regarding the use of narratives can be seen as objectifying and could do violence to the persons narrative. For example, Denzin as cited in Tovey (1998) states in regard to using narratives that

It is important to keep in mind that the basic theme of the life history is the presentation of experience from the perspective of the focal subject or subjects. Their world must be penetrated and understood. Once it is entered, the observer lays out the critical objective experiences relevant to that world… (p.178).

Nussbaum as cited in Murray (1997) supports this notion describing the prose style typical of modern Anglo-American philosophy as

… correct, scientific, abstract, hygienically pallid, a style that seems to be regarded as a kind of all-purpose solvent in which philosophical issues of any

kind at all could be efficiently disentangled, any and all conclusions neatly disengaged. It is a style perfectly suited to a conception of moral philosophy as a collection of isolable propositions" (p.44).

Others in bioethics seem more aware of the dangers involved in working with narratives in ethical decision-making. For example Hunter (1996) explains

While principles remain essential to bioethics and biological science must always inform good clinical practice, the tendency to collapse morality into principles and medicine into science impoverishes the two practices. In both instances such a reduction takes science as a model for what cannot be purely scientific. It is an attempt to know generally and abstractly what cannot be known except through the particular case-and to be best understood that case must be richly understood (p.316.).

Hunter further emphasises that "Clinical judgement and moral discernment are equally a narrative skill or capacity" (p.316). She elaborates that for clinical judgement and moral discernment, what is necessary is an accessible store of well-indexed experience. In this, Hunter (1996) is in complete accord with what Benner (1984) has already found in the case of nurses' ethical caring practice as discussed in Chapter Three.

Whether listening to the patient's narrative, or employing narrative skills in their own practice what is important to understand for healthcare professionals is that human beings are meaning-making creatures (Murray,1997). As such, "the meanings we look for and seek to construct in our lives are not collections of propositions. Meanings are better understood and conveyed as narratives" (Murray, 1997 p.55). In this way it can be seen that narratives can also function as a complement and supplement to the inadequacies of the principles only

approach criticised by many in bioethics. As Rogers and Niven (1999) put it "The focus is not on grand theories, but on the particular life-story which… is inevitably characterised by the series of narrations, descriptions, tales, chronicles, histories and accounts, which together produce a grand narrative" (p.95).

An ethic of care

An ethic of care, like the other alternatives or complements proposed above, has been developed at least in part, in response to the inadequacies of the principled based approach (Tong, 1993). However, apart from agreeing with the other proposed alternatives on the inappropriateness of applying abstract, impartial, decontextualised principles to the real life situations of clinical healthcare practices, an ethic of care was developed with a larger agenda. That is, an ethic of care challenges the very basis of the applied principle approach to ethical and bioethical decision-making that has been developed from, and is directly underpinned by, Rawls's theory of justice (Baier, 1995; Carse, 1998; Sharpe, 1992;). Carse, (1991) also includes an ethic of care as challenging "the ethical theory taught, the issues addressed, and the skills and sensitivities encouraged through bioethical education (p.5). Of particular note is the fact that it was the absolute adherence to "morality as justice" in Kohlberg's theory of moral development, grounded in the liberal political theories of Locke, Kant and Rawls (Sharpe, 1992), together with the use of all male participants in his trials, that prompted Gilligan's seminal work "In a Different Voice" (Gilligan, 1982). Sharpe (1992) clearly and effectively sums up the feminist position of the care perspective in relation to the applied principle approach. She states that,

> *Briefly, "morality as justice" regards the moral domain as entirely comprehended by the demands of equality, impartiality and universality. The image of justice, blindfolded and holding balanced scales, symbolises these norms. The care perspective, by contrast, finds moral salience in forms of human*

relating and responsiveness that arise between human beings who are seen by each other as precisely the particular unique human beings whom they are, rather than as abstractly conceived rights bearers. As a result, the care perspective allows for partiality as a legitimate moral point of view. In addition because the care perspective as attentive to real individuals rather than simply to individuals abstractly conceived, it acknowledges a moral significance of real inequalities that may in fact distinguish us. (Sharpe, 1992, p 296).

Sharpe (1992) further explains that these two orientations to moral understanding have developed into an extensive body of literature known as the justice-care debate, the implications of which have extended from moral psychology to the fields of moral and political philosophy, jurisprudence, and the natural and social sciences (p.295). This aspect of an ethic of care will be explored in more detail in Chapter Six

Like narrative ethics, an ethic of care is a newcomer to contemporary bioethics, without the inherited genealogical ties to the history of ethical thinking of ancient Greece, or the theology and law of the fourteenth century, carried by virtue ethics and casuistry respectively. However, interestingly, from a basic practical human perspective, care ethics and narrative ethics could be seen to predate both. In that, caring for each other and telling stories are as old as humanity itself. An ethic of care then, has not risen from within the genealogical lineage of bioethics but has been introduced into it from outside.

The proposal of an ethic of care as deserving of a place in bioethical decision-making, along with its radical larger agenda, has placed a number of challenges at the feet of bioethics. These challenges and the proposed ethic of care itself has, understandably received a mixed response. Critics from bioethics, nursing and feminist theory have all had some input into assessing the strength of the challenges and the ability of an ethic of care to deliver on them. According to

Allmark (1995), who is a nurse, "caring ethics is hopelessly vague. It lacks both normative and descriptive content" (p.19). In the view of Veatch (1998), a bioethicist, "Almost no one would suggest that care is a concept critical to metaethics (even if the care orientation is seen by many to be largely about foundational issues)." (p.211). He further states, "It is not clear how care maps onto the more traditional concepts in ethical theory" (1998, p.211). However, Veatch eventually decides that perhaps, while care ethics may not map onto traditional ethical theory, it may have a position in adding a new area to the map, if it is treating relationships as having normative content. Even if this were so Veatch, (1998) warns that there would still be several critical questions needing to be addressed in a theory of care (p.221). According to Carse & Nelson (1996), the fact that an ethic of care validates skills and virtues traditionally associated with women and women's roles, according to some feminists, could simply just reinforce the subordinate status and exploitation of women in society.

On the positive side, also in the feminists' view, many see that an ethic of care provides an answer to a "vital need for an ethic that takes the experiences of women seriously" (Carse & Nelson, 1996, p.19). Another serious challenge from an ethic of care to traditional justice based ethics is regarding the principle of autonomy. Many feminists see the emphasis on autonomy, which is fundamental to the liberal justice perspective underpinning Rawls' theory of justice, as supporting and perpetuating the myth of the independent autonomous individual as outlined in chapter two. This feminist perspective sees the emphasis on autonomy as an ideal as not enabling the understanding of the reality of dependence and interdependence in human life (Tong, 1993; Clement, 1998). However, true to the ability of the feminist perspective to actively encourage the wide contribution of many perspectives with respect, some feminists "appeal to the notion of autonomy in defending women's right to define themselves according to their own interests and needs (Clement, 1998,

p.21). The doubts surrounding autonomy will also be covered in more detail in Chapter Six.

An ethic of care then, put up alongside the other proposed alternatives and/or complements to the traditional application of principles as a form of decision-making in ethics and bioethics, stands out as a more radical challenge. To present a broader background to this challenge and allow a more comprehensive view of contemporary bioethics, this chapter will conclude with an outline of the major critiques of bioethics from the nursing and feminist perspectives as follows.

Nursing critique of bioethics

For the greater part of its history, nursing, despite its size and unique contribution to healthcare, was incorporated in the ethical sense into and under medical ethics. According to Johnstone (1994), at this time it was thought by many that "Nurses are not required to make independent moral judgements." (p. 4). The ethics associated with nurses and nursing was considered more a matter of feminine etiquette and that it was more important that nurses should be "good women but not bother with a code of ethics" (Johnstone, 1994, p.1). These relationships, as they were thought to exist, and the perspectives nurses, have of their practices of care have changed markedly from the mid seventies (Benner, 1984; Benner & Wrubel, 1989). Nursing now has, and is continuing to develop, its own ethics as distinct from medical ethics whose domain extends far beyond merely formulating a code of professional nursing ethics (Benner, 1991; Duldt, 1995; Fry, 1989, 1990, 1991; Fry, Killen & Robinson, 1996). Within the discipline there are in-depth scholarly debates on the entire range of subjects covered in bioethics today. These can be found in the well-established "Nursing Ethics" journal and virtually all other nursing journals have sections devoted to ethical issues, or at the very least publish individual articles on nursing ethics and general bioethical issues. Nursing conferences devoted to nursing ethics and bioethical topics are regularly held world-wide, and some

might say nursing has the beginning, if not more, of its own ethical research, theories and approaches (Astrom, Furaker, & Norberg, 1995; Benner, 1991,1994; Bishop & Scudder, 1990; Condon, 1992; Duldt, 1995; Gastmans, 1998, 1999; Hinson-Penticuff, 1991; Fry, 1989, 1991, 1996; Johnstone, 1994,1999).

However, at the practical level, as has been so aptly pointed out by Arras (1991) above in regard to reviewing clinical cases, or casuistic approaches to ethical decision making, nurses' equally valid perspectives are not consistently sought or included. Further to this, Arras (1991) also pointed out that at the practical level, nurses do not regularly participate in more general multidisciplinary discussions of an ethical nature. There could be several possible reasons for this. One is that of language difference. In this respect Johnstone (1999) emphasises that

> *In order to be able to discuss ethics, bioethics and nursing ethics in a meaningful way, it is important, first, to share a common and working knowledge and understanding of these (and other) fundamental ethical terms. Unless nurses use the same moral language and grammar as others, little hope remains of either agreement or disagreements being reached on what is considered a competing moral view (p. 40).*

Taylor (1997) points out that from her experience in practice as a nurse ethicist, that some nurses seem to be unaware, or lack the means to articulate the ethical nature of their practice (p. 68). In Taylor's view she recognises the importance of nurses working with nurses to identify and address nursing specific problems, and the advantages of having nursing ethics committees. However, she also points out that in her experience some of nurses' distress comes from tensions within the interdisciplinary team, and this raises "broader issues about human well-being that are best addressed by the institution or healthcare system at large" (Taylor, 1997, p.69). Taylor further emphasises that restricting

discussion of these concerns to within nursing only 'may result in their becoming trivialised or marginalized to the impoverishment of all." (p. 69), and change will not occur.

A further reason contributing to the perceived lack of nurses' contribution to ethical discussions, in regard to clinical situations, could be due to the theory-practice split. Nursing as a discipline has scholars in ethics, research on ethics, and codes of ethics but much of the work at this level doesn't seem to be transmitted or even more importantly be necessarily connected with the situation of nurses ethical awareness and ability at the practice level, as Taylor has pointed out above. At the same time, in the study by Woods (1997) he clearly demonstrated the presence of a robust nursing ethic in the moral practice of experienced nurses, involving an ethic of care along with a selection of other approaches. If this disconnection is a factor, this is clearly a nursing issue rather than a more general bioethical one, however its resolution would appear to the ability of nursing to contribute to bioethics.

In regard to nurses' contributions to bioethics, apart from the demise of traditional moral certainty, the increasingly post-modern context, and the different epistemological levels within contemporary bioethics, as previously established, another point of dissonance exists. This further complexity arises out of whether bioethics and ethics are understood as pertaining largely to conflict and dilemma situations, or as an ongoing part of everyday life. That is, is ethics more basically epistemological, a way of applying a particular knowledge in particular defined situations, or is it more ontological, a more continuous way of being in everyday life? The traditional approach, largely though not exclusively, adopted in medicine and by many bioethicists is mainly epistemological (Reichlin, 1994).

Both the nursing and feminist perspectives on bioethics are critical of this predominant focus and tend, though not in an absolute or exclusive way, more towards the ontological view of bioethics seeing ethicality more as part of ways of choosing to live life or being (Kheel, 1993; Roach, 1987) In an ontological perspective, to some extent all facets of life are deemed to have an ethical component. For example this would include the full range from the mundane so called "niceties" of please and thank you, up to and including the life and death issues (Seedhouse, 1997). In this view there is a more continual awareness of the ethicality and the impact one's everyday actions and decisions have on others.

Within bioethics there is some tension developing regarding the issue of whether ethics is seen as dilemma based or it is seen as an everyday occurrence, largely because it too challenges the traditional *applied* (my emphasis) principle approach (Seedhouse, 1995, 1997, 1998) In nursing Benner (1991) was first to highlight the importance of *everyday* skilled ethical comportment in nursing caring practices. She sees the reality of nurses' everyday ethical decisions not as separate from dilemma or quandary ethics, but as providing the essential foundation for addressing the quandary and procedural ethics or issues. Benner noted that "Quandary and procedural ethics *depend* (my emphasis) on everyday skilful comportment and practical moral reasoning that is formed by the particular knowledge of the embodied knower" (p. 1). Later in 1996 Komesaroff a physician, in a chapter from his edited book "Troubled bodies: Critical perspectives on postmodernism, medical ethics and the body", demonstrates a close parallel with Benner's view. Komesaroff points out a distinction between 'conventional bioethics' (quandary and procedural ethics) and what he terms microethics, within medical ethics. He explains that,

> "*Microethics starts from the premise that clinical practice consists of an accumulation of infinitesimal ethical events. Accordingly, its task is to chart the*

topography of the medical lifeworld, as it exists in its concreteness, its fluidity,
and its temporal unpredictability." (P.73).

However, Komesaroff (1996) makes it clear that microethics is not generally considered in debates about medical ethics, even though he considers it may be more important for the determination of medical outcomes than most other factors, He goes on to make an interesting point saying that an ethical dilemma

"in itself is often merely indicative of a deeper problem namely, the breakdown of
the communicative process between the participants so that… regardless of the
formulation, a 'microethical' solution that is one at the level of the actual
interaction between doctor and patient must ultimately always be found, so
there is no means by which the microethical realisation of discourse can be
circumvented" (Komesaroff, 1996, P.74).

It can be seen that Komesaroff, from the medical discipline, has eventually come to the same understanding as Benner did in her research in the discipline of nursing back in 1991, regarding the matter of whether ethics is and everyday occurrence or applies in dilemma situations only. Here a nursing and a medical perspective agree that there is no either/or dichotomy, that there is instead a relationship between them where quandary or dilemma ethics are dependent on and not separate from everyday ethical comportment or microethics. This perspective of the role of everyday ethical caring practices is a vitally important part of ethical caring practices in nursing (Benner, 1984; Benner & Wrubel, 1989; Parker, 1991; Watson, 1990a, 1990b).

This is not to say that from a nursing perspective principles should be done away with completely, as Cooper (1991) has pointed out, the tension between principle based ethics and other forms of ethical approach such as an ethic of

care can be a creative one rather than a mutually exclusive one. Patricia Benner in her book "from novice to expert" explained that principles are a stalwart for the novice nurse before she /he has the experience to develop and select from a more eclectic, individual experience based ethical approach. Various possibilities for alternatives to the principlist approach have been explored within the discipline of nursing (Gibson, 1993; Johnstone, 1994, 1999), including several of the alternatives supported by the medical fraternity within bioethics (Artnak, 1995, Dimmitt & Artnak, 1994; Gaul, 1995). However, due to the fundamental position of caring in nursing it has been an ethic of care that has received the major focus (Benner, 1984, 1991,1994; Benner & Wrubel,1989; Carper, 1979; Fry, 1989; Watson & Ray, 1988). Even so, as with the feminist perspective, some nurses support an ethic of care and some are against it, while others prefer an ethic of care being in conjunction with other approaches in nursing as for example Woods 1997) has found in his research.

Nurses and the nursing discipline have a lot to contribute to the bioethical debates and discussions. This is both from the depth of their experience and extensive emersion in the intimate relations necessitated in the practices of care with their patients, and from their explorations of ethical issues and alternatives in ethical decision-making. However, although nursing ethics is a distinct body of work, in the study of the literature for this thesis, nursing ethics scholarship rarely makes frequent appearances in the established bioethical journals used in this study, except as the occasional individual article, or even more rarely as one particular edited issue of a bioethical journal. For example, in 1991 Sara Fry was editor of one issue of The Journal of Medicine and Philosophy volume sixteen, titled "Nursing Ethics: Current State of the Art". The pattern appears to be in general that nurses publish their bioethical/ethical articles in their own journals and the medical fraternity and bioethicists publish in their established medical/bioethical journals.

The feminist bioethicists, although growing in numbers and now resident in some of the bioethical schools and institutions, particularly in the USA for example, Alisa Carse, and Margaret Little at the Kennedy Institute at Georgetown University, are not regularly, or as commonly published in the bioethical journals. They are also less frequently represented in the bioethical databases such as bioethics line relative to medical professionals and bioethicists and male moral philosophers. For example only two issues in eleven years, between 1990 and 2001 are concerned with a nursing perspective of ethics and an ethic of care. The one mentioned previously (Fry, 1991) and more recently one edited by Margaret Little and Robert Veatch in 1998, with the dubious title "The Chaos of Care and Care Theory", volume twentythree, number two.

The other main bioethics journal available in New Zealand, The journal "Theoretical Medicine and Bioethics" had no complete issues concerning nursing ethics or an ethic of care at all in the same period. Patricia Benner had one article published in this journal, volume eighteen in 1997. In a strictly informal assessment of the references taken from bioethical journals used in this study, out of a total of 70 bioethical journal articles, 31 mentioned caring and/or nursing. Of those eight were authored by recognised nurses, fifteen by recognised feminists or feminist bioethicists, and nine by physicians or bioethicists. This is just to give an idea, and carries no statistical weight. Moreover, as far as using the representation of an ethic of care and or nursing in bioethical journals as a criticism of bioethics, the full range of contributing factors are not known. However, speculatively, it is likely that it is, at least in part, nursing issue as well as a bioethical one.

Feminist critique of bioethics

Quite apart from the challenges that an ethic of care makes to the predominant approach of applying abstract principles to bioethical situations in healthcare,

and challenging the emphasis on justice and autonomy, feminists have even broader criticisms of traditional ethics and philosophy. In particular, feminist moral theorists point out that there is a gender bias in philosophy itself, and it has a consequent effect on ethics in general and bioethics in particular. Further to this, despite its claims, traditional moral philosophy has not succeeded in supplying as promised a sound reliable universal moral theory, and last, that a difference exists between male and female moral thinking

According to Kersey (1989) "The history of philosophy, particularly ancient philosophy, has been a history of men. From its recorded beginnings…Western philosophy… was created by, for, and about men" (p.1). The gender bias is found in both popular and standard texts such as dictionaries, philosophical reference works, encyclopaedias, and histories of philosophy (Johnstone, 1994) These texts make little, and in most cases, no reference at all, to the philosophical contributions of women; in fact, the accomplishments of many hundreds of women philosophers have been omitted (Kersey, 1989; Johnstone, 1994).

According to Kersey (1989) and Johnstone (1994) there has been a substantial contribution by women to philosophy and ethical thinking, retrieved from history as far back as the 6th century B.C. Pythagorean mothers, who developed moral theories based on harmony, friendship, compassion, courage, care, and justice, through to Dorotea Bocchi, who succeeded her father as professor of medicine and moral philosophy at the University of Bologna (Alec as cited in Johnstone, 1994), Elizabeth of Bohemia, and Mary Wollstonecraft, to current 20th century female philosophers, and moral philosophers. Kersey (1989) points out that many of the works of women philosophers were destroyed and lost, some as in the case of Olivia de Nantes Barreta Sabuco (1562-1625) who wrote a philosophical book "Nueva filosofa" had her work destroyed by the Spanish Inquisition. She later republished her book but "Characteristically history has

attributed the work to her father", although it still bears her name (Kersey, 1989, p.10).

The reason for the bias appears to be the historical powerful influence of philosophers such as Aristotle, Aquinas, Rousseau, and Kant. Their influence has been overwhelming both inside and outside moral philosophy as in society in general, women are still regarded as being rationally inferior to men, emotionally fickle, and unstable for positions of authority (Johnstone, 1994). As Johnstone elaborates, this is evidenced by, the under representation of women in government, business management, professorial chairs, and religious leadership. Such a long-standing historical lack of inclusion of the experience of virtually half of the world's population in determining how best to live and organise our affairs clearly shows an inadequacy in traditional ethics.

The absence of the one grand universal theory in ethical theory is quite clearly evident. The number of competing, and complementary approaches to ethical deliberation already presented illustrates this well. However the perceived difference in male and female thinking is more problematic. Some have read Gilligan's work as providing proof of a definite gender based difference with females adopting the care approach and males adopting the justice approach. As explained in chapter three, Gilligan did not make this absolute judgement, pointing out in her early work that it was *by theme* she heard the different voice, and that some men adopted the care approach and some women the justice approach (Gilligan, 1982). Sharpe (1992) puts this aspect of care ethics in perspective as she states that even though Carol Gilligan's research discerns different themes between the moral concerns of men and women,

> *…it is important to point out that these findings do not affirm that there should be distinctive women's and men's moralities. Rather than reiterating or reinforcing the archaic notion of separate gender-defined moral realms,*

Gilligan's work shows that an accurate understanding of moral competence must encompass those skills and forms of human relating that have heretofore been neglected or dismissed by contemporary moral theories (Sharpe, 1992, p.297).

Gilligan herself confirms this in her later research where she found that both men and women can come to use both care and justice approaches, and that even though more women were likely to use the care approach predominantly, and men the justice approach predominantly, the main point is "a different voice has been heard and a new direction charted" (Gilligan, 1995, p.126). However, the question of whether morality is in fact gendered, in an essential manner, and if it is seen as gendered in such a way then how, or rather what, determines its gender, remains an ongoing debate in the field of bioethics in general.

Summary

This chapter has continued the focus of chapter four on bioethics as the subject in order to continue and enrich the laying out of a view of the bioethical landscape in which caring may have a place. However, in this chapter the orientation is towards the present rather than the historical past, and a current picture of the main features of contemporary bioethics and a critique from a bioethical perspective of the predominant principle based approach to ethical decision-making. Part of this critique involved the proposal and outline of some different approaches as alternatives or complements to the application of abstract principles, particularly in clinical situations. This included an ethic of care as one of the contenders. Finally, the nursing and feminist perspectives have contributed an outline of their major criticisms of contemporary bioethics. Several of the points raised by their criticisms in this chapter, supported by notions of caring and an ethic of care from chapters two and three, will be the subject of the following chapter six. This signals a shift to the next phase of the

study that is, exploring some pathways to a possible place for caring as an ethic of care in bioethics.

POSSIBILITIES FOR A PLACE FOR CARING IN BIOETHICS: ADDING SOME NEW LENSES

There are more things in heaven and earth Horatio…

(Shakespeare, "Hamlet")

Introduction

In this chapter the work of Chapters Two and Three focused on the importance of caring and its ethical aspects to human health, development, quality of life and survival, together with the work of chapters four and five on presenting a lay out of the nature and landscape of bioethics as a topographical map of the field, are brought together. The juxtaposition of the phenomenon of caring and an ethic of care, and the field of bioethics, including the critiques of caring and bioethics from all three disciplinary perspectives in the previous chapters, draw the attention to three apparently critical focal points regarding the possibility of a place for caring and an ethic of care in bioethics. These are the care-justice dichotomy, the interpretation of the concept of autonomy, and aspects of the relationship of caring and virtue ethics. An explanation of these critical focal points, and some of the possibilities for their resolution are presented as the subject of this chapter.

Undoing the care-justice dichotomy

The development of an ethic of care and its consequent challenge to a traditional justice based ethics and bioethics has, as Sharpe (1992) pointed out in chapter five, given rise to a large body of literature on the subject. In this study so far, the case in support of caring and an ethic of care that has been collectively presented in chapters two, three, and five, regarding the

fundamental nature and importance of caring, and relation in human life, (Berry, 1985; Buber, 1970; Heidegger, 1962; Montagu, 1975), together with the development of an ethic of care focused on response to needs, the interrelatedness of human beings, and the importance of relationships between persons (Bowden, 1997; Gilligan, 1982; Noddings, 1984; Tronto, 1993), appears to indicate a serious challenge to the traditional justice based principlist ethics and bioethics. In return traditional bioethics has either summarily dismissed the possibility of an ethic of care as being taken seriously or has used a number of different strategies to deflect or remove the basis of the challenge (Carse, 1991, 1993, 1998; Gatens, 1998; Held, 1995; Little, 1996,1998;).

The pivotal situation

What is significant about the much reviewed, argued and debated relationship between an ethic of care and an ethic of justice, and their relative merits and demerits, is that they have tended to be framed so that they are seen from an oppositional or dichotomous perspective. This perspective though not necessarily technically incorrect in some views, takes only the bones of the situation and sets up traditional justice based bioethics, very tightly framed as focused on the rights of independent, rational, autonomous individuals that are determined from an abstract impartial point of view (Held, 1995). While on the other hand, an ethic of care is tightly framed as focused on the response to needs of persons who are seen as interdependent, and as existing in contextually bound, historical and particular relationships (Gilligan, 1982).

This dichotomous framing is not helpful in progressing past an either/or position for an ethic of care and an ethic of justice. It is too spare and simplistic a position to provide seeds of possibility for its management or more hopefully its resolution. According to Clement (1996) this resolution is important because the ethic of care and the ethic of justice

are especially worthy of our attention because they are not merely two among many different approaches to ethics. They are more fundamental than other possible ethics because they thematise two basic dimensions of human relationships, dimensions that might be called vertical and horizontal. The ethic of justice focuses on questions of equality and inequality, while the ethic of care focuses on questions of attachment and detachment, and both sets of questions can arise in any context (p.1)

Further to this, Clement points out Carol Gilligan has written,

…both inequality and detachment constitute grounds for moral concern. Since everyone is vulnerable both to oppression and to abandonment, two moral visions -- one of justice and one of care -- recur in human experience. The moral injunctions, not to act unfairly towards others, and not to turn away from someone in need, capture these different concerns" (Gilligan as cited in Clement, 1996, p.1).

Therefore, the importance of finding elements of connection and compatibility within the ethic of care and the ethic of justice can be seen, particularly if an ethic of care is to find a place of acceptance in bioethical decision-making.

Discussion

As the nature of an ethic of care has already been covered in chapters two, three and to a lesser extent in chapter five, it is pertinent here to briefly outline the theory of justice as developed by Rawls (1971). Following this some of the main approaches, and positions of objection that have most frequently precipitated out of "the care-justice debates" will be examined.

In 1971 John Rawls published his book "A Theory of Justice" in which the foundational idea is that of justice as fairness. Justice as fairness is based on "the hope that social institutions do not confer morally arbitrary lifelong advantages on some persons at the expense of others. This condemns as unjust not only racial, sexual, and religious discrimination, but also many forms of social and economic inequality." (Nagel, 1995, p.745). This perspective of justice, according to Nagel (1995), is a strongly egalitarian form of liberalism based on a form of social contract theory that is not an actual social contract, but a hypothetical one (p.745). He further explains that in this theory, we are to imagine ourselves in an "original position of equality" otherwise known as the "veil of ignorance", in which we do not know most of the socially significant facts about ourselves, for example race, sex, religion, economic class, social standing, natural abilities, even our conception of the good life.

Nagel (1995) continues that from this imaginary point of view "we are to decide what principles we could agree to, on the basis of the desire to further out own aims and interests, what ever they may be."(1995, p.745), and he elaborates that for Rawls

> *not knowing our position in society or our conception of the good, we are driven by this fiction to an equal concern for the fate of everyone, and Rawls maintains that we would give priority in choice of principles to avoiding the worst possible life prospects, with emphasis first on the preservation of personal and political liberty and second on the amelioration of socio-economic inequality (Nagel, 1995, p.745).*

The principles Rawls defends are,

(1)   Each individual is to have a right to the greatest equal liberty compatible with a like liberty for all

(2)   (a) Social and economic inequalities are to be attached to offices and positions open to all under conditions of fair equality of opportunity; and (b) such inequalities are justified only if they benefit the worst off (Nagel, 1995, p 745).

In Rawls' theory the first principle has priority over the second, and both principles are to govern not detailed political choices, but the basic political, economic, and social structures that determine people's chances in life. According to Rawls as cited in (Nagel, 1995) "Equal liberty rules out persecution, discrimination, and political oppression. Equal opportunity ensures that those with equal ability and motivation have equal chances of success, what ever class they are born into" (p.745). In general Rawls claims that "the right is prior to and independent of the good, and cannot be defined is that which will promote or maximise the good" (p.745). In later essays Rawls developed the theory of justice and its relation to general moral theory further by employing what he calls the method of "reflective equilibrium". In this he means that, in a situation where there are several moral views, coherence is achieved through mutual adjustment between particular moral judgments, general principles, and theoretical constructions that model the ideas of morality (p.746).

From a feminist perspective, according to Clement (1996), a major approach to the care-justice debate is the one that celebrates an ethic of care as a feminine ethic, and seeks the recognition of women's activities and experiences that have traditionally "been ignored or devalued by male-defined moral theory" (p.2). In this view, Gilligan and Tannen, in separate studies, as cited in Sharpe (1992) point out that, "empirical research has shown that the justice orientation is over

represented in males and that the care orientation is over represented in females" (p.296). Sharpe (1992) continues that

> *For this reason, the issue of gender is germane to the difference in moral perspective….insofar as the justice perspective, which is the dominant voice in contemporary moral theory, excludes the perspective of care, it fails to give moral credit to or even to address many of the concerns that have historically been associated with woman's experience (p.296).*

Clement (1996) further supports this view and explains that

> *Even if many women do not use the ethic of care, this ethic undeniably captures a widely held view of what women are and ought to be. The ethic of care is socially coded as a feminine ethic, while the ethic of justice is socially coded as the masculine ethic. We need not make any false generalisations about women to recognise that woman's traditional activities and experiences are especially relevant to a study of the ethic of care (p.3)*

Clement goes on to explain that advocates of the "feminine" approach, "do not necessarily believe that all or only women use this ethic, their interest in the ethic arises because (they believe) that women especially use it" (1996, p.2). The main feature of the feminine approach as Clement points out, is that the ethic of care is moved from the periphery to a more central position in moral theory. It is thought that in doing this to reveal that the dominant ethic of justice with its emphasis on autonomy is often dangerous and illusory (Clement, 1996, p2). However, Clement (1996) notes that a criticism of claiming the ethic of care as a women's ethic put forward from the feminist position is, that it puts the advocates of the feminine approach very close to taking up a form of essentialism. The feminist position is against the generalised assuming of an

essentialist view and is very strongly supportive of allowing for unique and individual choice, and the expression of those choices. (Jaggar, 1995; Silvers, 1997).

A second and less directly oppositional approach to the justice-care debate, according to Clement (1996) is the assimilation of the ethic of care into a justice perspective. She explains that many traditional moral philosophers who adopt this approach see gender and ethics as separate and distinct. As Clement elaborates, those that adopt this approach hold that the deplorable things historical philosophers have had to say about women can and should be distinguished from what they have to say about morality (p.3). Clement (1996) claims that by confining attention in this way it construes the care/justice debates as "being simply contemporary versions of the Kant/Hume debates over the roles of reason and sentiment in morality." (p. 4). According to Clement (1996) the traditional bioethicists position is, that even if most moral philosophers have had little to say about care issues, their moral theories generally allow for the ethic of care. What is required is to simply re-examine the ethic of justice to see whether and how it can accommodate an ethic of care's concerns. In short according to the assimilation approach the ethic of care need not be rejected, but neither is it an important development in moral theory in it own right (Clement, 1996).

Clement's (1996) own response to this "assimilation" approach is to point out that the ethic of care studied from a feminist perspective has brought out critical attention to the gender coding of our moral concepts, and it has clarified and challenged the sexual division of moral labour. Clement herself believes that the ethic of care and the ethic of justice are in many ways compatible. However, she is emphatic that simply "assimilating care into the ethic of justice cannot (emphasis original) be done in a way that gives care equal status to justice. It can only be done by interpreting care through the perspective of justice, thereby

devaluing and marginalizing it" (p.5). As pointed out by Little (1996) in chapter three, that which is coded feminine, as the ethic of care is, would be regarded as less important than that which is coded masculine as the present ethic of justice is.

Carse (1998) agrees with Clement but takes up the argument against accommodationist strategies for dealing with an ethic of care in more detail. In doing so she provides a very sound case for the inclusion of an ethic of care as an important development in moral theory in its own right. The heart of this case extends from the most pervasive dichotomy in the care-justice debates, that of the abstract and impartial tenets of the justice ethic verses the concrete and particular tenets of an ethic of care. The first accomodationist strategy according to Carse (1998) is viewing the constraint of impartiality as no more than the norm of fairness (p.155). In this construal Carse states that,

> *A commitment to impartiality does not in and of itself rule out the possibility of acknowledging special obligations and duties rooted in our particular roles and relationships, nor need it rule out as morally irrelevant particular features of our identities, interests, attachments, or special needs (Carse, 1998, p.156).*

She goes on to say that correlatively, giving close attention to particulars is not at odds with a conception of moral injunctions as universal injunctions. According to Herman and Sher as cited in Carse (1998) "impartial principles can contain a high degree of specificity and nuance without losing their universal normative force" (p. 56). Carse's rejoinder is that this accomodationist strategy is still essentially based on a model of principled judgement, which is a model that conflicts with the model of understanding and agency of the care orientation. Carse (1998) explains that in an ethic of care moral judgement is not characterised by a conscientious adherence to principle, "Moral judgement, even paradigmatic forms of moral judgement, can be generated by direct

response to another, without any guidance or mediation of categorical considerations" (p.157). However, Carse is careful to point out that this does not mean that every moral response (in an ethic of care) is a seat-of-the-pants response"(p158). She further explains that

It is instead an acknowledgement that there are sources of moral wisdom and insight that lie outside the reaches of categorical principle. It can matter less that we find general reasons for action than that we have well-formed dispositions to notice and attend to the conditions of others (Carse, 1998, p.158)

Following on from this in a greater depth Blum as cited in Carse (1998), points out

A compassionate or sympathetic attitude, a habit of paying attention to others, a sensitivity to others' needs -- these are components of a person's moral make up that she brings to a situation and yet that cannot be cashed out (in terms of conscientious adherence to) universal principles of action. A person can learn to be more compassionate; this does not mean that she comes to hold new action-specifying principles. What is learned in previous situations is not only which principles to consult an action but, as Murdoch (1970) emphasises, what to notice, how to care, what to be sensitive to, how to get beyond one's own biases and narrowness of vision (p.158).

In order for impartialist principles to accommodate such complex processes, the accommodationist approach would have to be formulated in "sufficiently intricate terms to capture morally relevant exigencies of the case at hand, yet in a way that generalises appropriately to all morally relevant similar cases" (Carse, 1998, p.160). As Blum cited in Carse (1998) explains, in such a view, "The principle in question is likely to be so cumbersome that few would be

likely even to try to make explicit use of it" (P.160). In this view then, Carse (1998) points out that therefore

> *an account of moral judgement as impartial and principle-derived cannot, in an ethic of care, provide a full picture of how we come properly to judge what we ought to do, no matter how intricate and nuanced-how encumbered-our picture of moral principles is allowed to be (p.161).*

What is remarkable about an ethic of care is that not only does it "see different features of cases as morally relevant, it also counsels *attention to differences*"(emphasis original) (Carse, 1998, p.166). Where as, the process of abstraction exerts "normative pressure in the direction of attending to commonalities rather than difference"(Carse, 1998, p.166). In challenging the impartialist perspective Carse cautions against "embracing too rigid a view about the nature of impartiality or too limited a conception of the role principles can play in moral deliberation and response"(1998, p.166), while maintaining awareness that focusing on impartiality has had "the effect of ascribing a derivative, secondary status to forms of epistemic skill-involving nuance and particularity-that are, from the perspective of care, often of first importance" (Carse, 1998, p.166).

In summing up, Carse's examination of an accomodationist strategy that would see an ethic of care fitting into existing impartialist ethical theory, has demonstrated two important points if there is to be some reconciliation. In her detailed and meticulous examination Carse (1998) has shown that there is a reasonable amount of flexibility in the focus of impartiality in the ethic of justice. This eases it away from a totally oppositional position, which gives hope to possibilities for connection. Meanwhile at the same time, Carse (1998) has clearly demonstrated that an ethic of care really is a new approach to ethical deliberation, and not a re-representation of something already in existence. She

has also demonstrated that in its very complexity an ethic of care contributes a valid and valuable approach not currently provided for in contemporary bioethics.

Possibilities

In both non-feminist and feminist writing the ground work is now being established for progression from a dichotomous view of the justice and care ethics to the recognition and exploration of the possibilities of some form of integration of the two. For example in the view of Baier (1995),

> *there is little disagreement that justice is **a** social value of very great importance, and injustice an evil. Nor would those who have worked on theories of justice want to deny that other things matter besides justice. Rawls, for example, incorporates the value of freedom into his account of justice, so that denial of basic freedoms counts as injustice. Rawls also leaves room for a wider theory of the right, of which the theory of justice is just a part. Still, he does claim that justice is the 'first virtue' of social institutions"* (p. 47-48)

She goes on to explain that in her view "the differences are as much in emphasis as in substance, or we could say that they are differences in tone of voice…For "care" is a less authoritarian humanitarian supplement, a felt concern for the good of others and for community with them" (p. 48).

Clement, (1996) also argues that real possibilities exist for an ethic of care in ethics and bioethics as she makes the point that " just as it is a mistake to ignore care's social context, it is also a mistake to reduce the ethic of care to the distorted ways it is often practiced. We can look for the moral and political possibilities implicit in the ethic of care while actively addressing its dangers." (p. 4). According to Clement (1996), it is looking at the ethic of care and the ethic

of justice only in their idealised forms where they are presented in a dichotomous relationship that perpetuates the idea that these two ethics are necessarily mutually exclusive. Clements' own approach to undoing the care/justice debate is to acknowledge that both ethics exist in a variety of forms, and that by distinguishing between better and worse versions of an ethic of care rather than simply accepting or rejecting it outright, and matching it with more compatible versions of the ethic of justice she believes it possible to develop a feminist ethic of care. Even an ethic of care that can usefully and adequately cross the public-private boundary as demonstrated by Di Quinzio and Young in their edited book *Feminist Ethics and Social policy* published in 1997.

There appears to be a growth in an awareness that we need more than Justice but that care alone as an alternative cannot carry the full moral load (Baier, 1995). Finding a compatible functional way to use both ethics that preserves the best of both approaches is a worthwhile goal that has enormous implications for the discipline of bioethics (Carse, 1998; Clement, 1996). It also appears to be particularly important for a bioethics in a state of transition, searching for better ways to address the increasing demands of rapidly growing population health needs, even more rapidly changing technological advances. This is not least important in ensuring that the so-called private realm receives appropriate versions of justice and care that acknowledging and deal with domestic violence and exploitative caring relationships. Ruddick (1995) supports this idea, pointing out that confining justice to the public realm allows people's vulnerability to violence and other harms (p.218) At the same time the public realm can benefit from the adoption of appropriate versions of the ethic of care (Ruddick, 1995, p.218). For example, this could occur in some areas such as workplace relations, or negotiation and conflict resolution.

The main point here is that there are possibilities. It is important that points of tension and conflict are not framed in a dichotomous way that suffocates

creativity and progress towards resolution. As Miller (1976) explains, the fundamental nature of reality is the fact that, in its most basic sense conflict is both inevitable and the source of all growth. When points of tension and conflict are confronted respectfully and openly they can provide pathways to connection and growth (Miller, 1976, p. 125-128). The next critical or focal point regarding conceptions of autonomy is in part related to the care-justice debates as it a disputed aspect of both the care and the justice perspectives.

Autonomy and care

In Western traditional philosophy autonomy holds a central position, however it is a position that is not necessarily central beyond that tradition (Davis, 1990). According to Clement (1996) "most literally, autonomy means self determination. An autonomous person is one who is in control of his or her life rather than being controlled by outside forces" (p.22). The concept of autonomy is deeply entwined in our personal understanding of whom we are as human beings. Taylor as cited in Nedelsky (1989) states "The image of humans as self determining creatures…remains one of the most powerful dimensions of liberal thought" (p.8). Nedelsky (1989), herself elaborates that for those of us raised in liberal societies the notion of freedom " takes its meaning and value from the presupposition of our self-determining self-making nature" (, p.8). Although more or less taken for granted by many, autonomy is a deeply complex concept in the different ways it is perceived, constituted and defined.

The complexity and different perceptions of autonomy give rise to a number of tensions in its meaning, significance and practical application in politics, law, nursing, feminism and bioethics. In regard to the aims of this study to explore possibilities for a place for caring as an ethic of care in bioethics, significant tensions arise concerning different conceptions of autonomy, and the compatibility of autonomy and care in the feminist and nursing perspectives. As some of the constellation of issues and tensions specifically concern the

soundness and acceptability of an ethic of care, the concept of autonomy will now be explored in some detail.

The pivotal issue

Autonomy was originally born of Kantian ethical theory and it is incorporated as a fundamental part of Rawls' egalitarian justice theory. This theory as outlined in the previous section on the care-justice debates underpins much bioethical deliberation and decision-making. Autonomy is also a foundational principle in traditional bioethics, and continues to have a strong presence, although changes are in process (see chapter five). This liberal and justice oriented conception of autonomy then, has a history steeped in Cartesian ideals of abstraction, reduction, and patriarchal ideology which feminist theory and ethics find difficult to accommodate and in many cases would prefer to reject outright.

The basis for this rejection from a broad feminist perspective according to Nedelsky (1989) is that this conception of autonomy " takes atomistic individuals as the basic units of political and legal theory and thus fails to recognise the inherently social nature of human beings" (p.8). However, Nedelsky is careful to point out that "no one among the feminists or communitarians is prepared to abandon freedom as a value, nor, therefore can any of us completely abandon the notion of the human capacity for making one's own life and self" (p.8). Nedelsky (1989) goes on to explain that "Indeed, feminists are centrally concerned with freeing women to shape our own lives, to define who we (each) are, rather than accepting the definition given to us by others" (p.8). This tension is the first part of the pivotal situation.

Clement (1996) agrees with Nedelsky (1989), that feminists are divided on the value of autonomy (p.21). However, Clement (1996) explains that there is

another significant tension related to the feminist perspective of autonomy, which causes a feminist division on the valuing of an ethic of care (p.21). This tension stems from the issues already discussed in chapters two and three regarding the feminist perspective of an ethic of care not only growing out of women's oppression, but also perpetuating it. While others (the feminine approach) argue that women's experiences and activities are sources of strength, and that challenging women's oppression requires celebrating these differences, one of which is an ethic of care. Clement further explains that,

> *There are important connections between these two debates. Many feminists who reject the ethic of care do so because they believe it undermines some notion of autonomy. For instance, whereas an autonomous individual defines herself, it is argued that an adherent of the ethic of care allows herself to be defined by others-by those for whom she cares. Similarly, those who criticise the notion of autonomy often do so because they believe it is inconsistent with an ethic of care…based on the recognition that human beings are socially constituted (p.21).*

In sum, according to Clement (1996) from this view it seems that the liberal conception of autonomy as one that arises out of certain individualistic assumptions of the ideal type of the ethic of justice, is incompatible with an ethic of care. From Nedelsky's (1989) perspective "the problem… is how to combine the claim of the constitutiveness of social relations with the value of self determination"(p.9). She eloquently concludes that while

> *liberalism has been the source of our language of freedom and self determination. The values we cherish have come to us embedded in a theory that denies the reality we know: the centrality of relationships in constituting the self (Nedelsky, 1989, p.9).*

For an ethic of care to have some possibility of a place in bioethical decision-making, from a bioethical perspective, the apparent incompatibilities between the liberal understanding of autonomy and an ethic of care need to be addressed. However that is not sufficient in-itself, the tensions and divisions within the feminist perspective on an ethic of care and autonomy also need to be dealt with in an acceptable manner in order to strengthen an ethic of care's case for a position in bioethics.

Discussion

Clement (1996) argues that the main problem in preventing the connection and reconciliation between care and autonomy lie in looking at autonomy only as it is portrayed in the ideal type of an ethic of justice, and pitting it against the ideal type of an ethic of care. She points out that both ethics' ideal types have important flaws and that a case for care and autonomy as compatible can be made. An attempt to reconcile care and autonomy is important According to Clement (1996) in that,

> *Autonomy (properly defined) serves as a criterion for an adequate ethic of care. That is unless a version of the ethic of care allows for the autonomy of the caregiver and the care recipient, the ethic of care will be deficient on moral and on feminist grounds (p.21-22).*

Further to this Clement elaborates that

> *If it can be shown that there need not be a conflict between care and autonomy, the debate can shift from whether care or autonomy is more important to how we might bring about the social conditions to allow us to overcome their present conflict (p.22).*

Part of the present conflict broadly construed is that the intensely individualistic "self made man" conception of autonomy does not take into account that "we come into being in a social context that is literally constitutive of us" (Nedelsky, 1989,p.8). Clement (1996) provides an account of liberal autonomy that assists in understanding this conflict and some way that it can and has been challenged.

According to Clement (1996), most discussions of autonomy regard it as a psychological attribute related to free will where persons are seen as self-determining. She explains that there are two general categories of impediments to psychological autonomy in the usual liberal view. The first is that autonomy requires that one be free of coercion in one's decision-making, the second is that it is necessary to think reflectively or critically about one's choices (Clement, 1996). She further explains that in this way autonomy is understood as having a negative component to not be coerced, and a positive component to critically evaluate one's choices. In this psychological conception of autonomy "if the sources of an agent's choice meet the above two conditions then the agent is self-determining" (Clement, 1996, p.23).

This concept has been challenged as Clement (1996) explains, because "meeting these two criteria is still not sufficient to be autonomous" (p 23). This overlooks the social embeddedness of our critical reflections. She points out that,

> *the primary reason for requiring critical reflection, or higher order desires, is that our ordinary desires, our first-order desires, are often socially determined (emphasis added).When we reflect on these desires we may realise that they are not really our (emphasis original) desires. Thus autonomy requires that we take a critical perspective on our socialisation" (Clement, 1996, p.23).*

Clement further explains that the realisation that critical reflection is itself a social product has led philosophers to search for ways in which an individual can elude his or her socialisation and thus be autonomous in the ideal conception. She emphasises that although no one can escape his or her socialisation, it is obvious that some people are more autonomous, that is, in control of their lives, than others, and that we can recognise that critical reflection allows people to be more autonomous than they would be otherwise.

The results of this thinking according to Clement (1996) present two approaches to the question about social constitutiveness and autonomy:

> *On the one hand, we can define autonomy and then consider whether anyone achieves it. On the other hand, we can observe the differences between people we consider autonomous and people we consider non autonomous, and then make generalisations about what constitutes autonomy. The first approach results in a purer conception of autonomy than the second: The autonomous individual can call everything into question. However it does so by ruling out the possibility of autonomy; it stalls when it is faced with the fact that we are socially constituted. The second approach results in a more limited, descriptive conviction of autonomy, one that accepts the social constitution of the individual. Unlike the first approach, however, this approach is practically helpful in focusing on what allows individuals to control their lives to extend that they do. (p.24)*

If we are concerned with the conditions that allow individuals to be as in control of their lives as they can be, Clement (1996) continues, it becomes obvious that those conditions are not only psychological but social as well and therefore we need to expand upon standard accounts of autonomy (p.24).

The first feature needing to be recognised in an expanded account of autonomy is that autonomy itself cannot be achieved individually, that is alone. "In fact, we learn to become autonomous, and we learn this competency not through isolation from others, but through relationships with others. An individual's autonomy is nurtured through the care of others"(Clement, 1996). Clement notes in regard to the liberal conception of autonomy, that isolation may promote the negative component, that one not be coerced, but it undermines the positive component to critically reflect on our decision-making. She explains that it is the support and guidance of our family, friends and teachers that foster the skills of self-examination allowing us to be autonomous, in other words, relationships with others teach us to be ourselves. Code cited in Clement (1996) puts it personal uniqueness, creativity, expressiveness and self-awareness... grow out of interdependence and continually to impact would affirmation and continuation to (p 24). Clement (1996) is careful to point out that some relationships foster these skills better than others and some relationships actually undermine these skills. "But relationships, and specifically caring relationships, are a necessary precondition for autonomy" (p24).

Further to this, in taking note of the social conditions that allow individuals to be as in control of their lives as possible another point requires recognition. As Clement (1996) explains "One need not be coerced, in that one is literally forced to carry out someone else's decisions, in order to lack control over one's life" (p24). Clement provides an example of the decision of a battered woman's to remain with her batterer, which she explains may be the best option available to her, however the fact that she makes this decision does not make it an autonomous decision. Therefore, literal force is not necessary. In Clements' view cases such as this highlight the need to expand the concept of autonomy to include social conditions that influence the relative capacity of persons to set their own courses. She sees that literal coercion should be the limiting case in our understanding of autonomy, and relative power and disempowerment

should become the broader issue. Since there are degrees of empowerment, there are also degrees of autonomy.

Following from this then, the second condition for liberal autonomy, critical thinking, also takes on a broader meaning in the light of social factors that affect our ability to control our own lives (Clement, 1996). What needs to recognised at this point, are the culturally bound norms and sanctions that are part of the social factors that have such influence on how people live their lives. In summing up Clement states that,

> *The ability to think about our own decisions critically is largely dependent upon being in a society in which the society's norms, which subtly socialise us are critically analysed and discussed. This means that voices that challenge the status quo must be allowed or even encouraged to exist and to be heard in a social discourse on important social values. This discourse must be available to the average person, and society must be set up in a way that citizens are able to effect political change based on this discourse. There are degrees of critical capacity, and thus degrees of autonomy, but it is clear that our critical capacities are maximised in social conditions that permit and encourage us to critically assess and influence the social ideals that in turn shape our lives (Clement, 1996, p 25).*

Here Clement provides a lengthy but important explanation, and summation of this part of her re-conceptualisation of autonomy, which in turn directs the attention to the possibilities that this exercise may hold for an ethic of care.

Possibilities
In terms of addressing the ambivalent feminist perspective Clement (1996) and Nedelsky (1989) have indicated that there are possibilities for compatibility

between the liberal justice version of autonomy and the ethic of care. The tension between those who support an ideal ethic of care and see autonomy as an ideal with dangerous illusions of a profound individualism that has no place in an ethic of care, and those feminists, and non-feminists for that matter, who claim that the ideal ethic of care is deficient because it compromises women's autonomy, can be at least eased. To illustrate how this could occur Clement explains

> *Broadening our account of autonomy to include social factors eliminates the excessive individualism that conflicts with the ethic of care. It also allows us to focus on the core of the feminist criticism of the ethic of care, namely that it serves to disempower women… but the notion of autonomy I defend would certainly not conflict with being a caregiver, instead it would seek to empower caregivers by demanding that they have the power to carry out their responsibilities adequately. (Clement, 1996, p.26)*

There are further possibilities in that a version of liberal justice autonomy, in its support of respect for individuals, could be taken on board in a partial manner. Some feminists point out "care is distorted when the carer identifies so completely with the recipient that she looses her critical perspective" (Clement, 1996). A caregiver needs a healthy sense of self and sense of autonomy in order to see the care receiver as a person in their own right with both similarities and differences to themselves to be able to attend appropriately to the receivers real needs and requirements. Therefore some degree of autonomy is necessary so that caring is not detrimental to either the giver or the reciever

What Clement (1996) and to a lesser extent Nedelsky (1989) have demonstrated is that it is possible to close the division in the feminist perspectives on an ethic of care, and less fully developed but still a possibility, to quiet at least some of the criticisms of bioethicsts and other non feminists opposed to an ethic of care.

Clement has indicated it is the individualism of autonomy from the ideal type of an ethic of justice that is compatible with care, while the social emphasis of the ideal type of the ethic of care is incompatible with autonomy. Clement's (1996) response is that reconciling care and autonomy requires moving beyond the ideal types and examining different versions of both for compatibility to find the right balance between the connections and the separations between individuals. A further possibility for the developments in reconciling autonomy and care could be the development of new language to express the new thinking and ideas. According to Frazer and Lacey as cited in Clement (1996) they have developed the term "relational self to express a balance between care and autonomy.

It is important to signal here that autonomy is a concept also of deep significance in the discipline of nursing and to nursing practice, and in direct connection with the feminist perspective to nurses as mainly women (Condon, 1992). The significance of autonomy has, as with the feminist perspective, produced considerable literature, debate, discussion, and different perspectives. Autonomy is significant to nursing in three broad categories. First is in the relationship between the nurse and his/her patient, (Benner, 1984), second is in the nexus of relationships and hierarchies of authority in which the practicing nurse is embedded in the workplace, (Bishop & Scudder, 1990; Bowden, 1997; Yarling & McElmurry, 1986), third is in the establishment and acceptance of nursing as a professional discipline in its own right. This is too large to comprehensively cover in the constraints of this thesis, therefore for the purposes of this particular discussion, which is oriented toward the place and acceptability of an ethic of care in bioethics, and for reasons of time and space, the focus will be relatively brief and general.

Nurses and nursing are also ambivalent about the whole-hearted acceptance of an ethic of care, and in nurses' discussions their reasons are similar to those

raised by the feminist critique. Nurses see that adopting an ethic of care could be a trap hindering their growth as an independent discipline, following the same basic reasoning of the connection between patriarchal oppression, women and caring and caring work (Condon, 1992, Watson, 1990). Many would rather see the emphasis put onto either natural science or nursing as a human science, feeling that would confer greater legitimacy and acceptability as a discipline (Polifroni & Welch, 1999)

Some nurses point to the difficulty of nurses' ability to act morally from a position where they are not able to control their practice in institutions to a satisfactory extent. That is, in this case they lack sufficient autonomy (Yarling & McElmurry, 1986) and don't necessarily see an ethic of care helping the lack of autonomy. This is not to say that, they are not acutely aware that caring and an ethic of care are fundamentally important to their relationship with their patients and the quality and ethicality of care they can give.

Further to this most nurses are aware that an ethic of care indubitably underpins nursing practice, even if they sometimes have difficulty expressing it, as pointed out in Chapter Five, and studies have demonstrated this (Benner, 1991; Woods, 1997). Therefore when looking at the possibilities of refashioning the concept of autonomy as outlined by Clement (1996) and Nedelsky (1989) above, it appears that much of what they have to say would be just as relevant to nurses and nursing. Particularly the broadening of the concept to recognise the social and cultural influences and constraints on people's decision-making both generally and morally. It is also important to point out that nurses have not been idle on this subject themselves and have also developed, and are continuing to develop, ideas and thinking concerning autonomy (Benner, 1984, 1991, 1997; Carper, 1979; Davis, 1990; Gastmans, 1998,1999, Johnstone, 1999; Ray, 1994; Scott, 1996, 1998 which may in return hold possibilities for the feminists to consider.

Summary

This chapter has diverged from the perspectives and predicaments presented in the previous 5 chapters, and brought the focus down onto two apparently critical focal points regarding the possibility of a place for caring and an ethic of care in bioethics. These were the debates concerning the care-justice dichotomy, and the different perceptions of the concept of autonomy. The pivotal point for each was explained and then particular issues concerning each were discussed and finally some of the possibilities for their resolution were presented. The final phase of looking back at the study as whole now follows in chapter seven.

CHAPTER SEVEN

DISCUSSION AND REFLECTION

Introduction

The focus of this final chapter is reflective rather than generative as the previous chapters have been. Its purpose is to present a summary of the conclusions or main points arising from this study. It also presents the limitations and an evaluation, followed by the significance and implications of the study, and finally recommendations for future work in this area In this final phase of the study it seems appropriate to re connect briefly with where it began. This study was initiated by a desire to understand more clearly what was behind the apparent dismissal, or at least resistance to the acceptance of an ethic of care as a valid approach in bioethics. It seemed to me as a nurse, so obvious and so important in terms of caring for human beings, real people with real lives in the processes of their experiences of health and illness, that an ethic of care was both valuable and necessary. It appeared even more important that caring, developed as an ethic of care, should be included in bioethical decision-making. This is now the place to look back and reflect on the nature of the journey, and what has eventuated in the process of that particular journey.

STUDY CONCLUSIONS

Main conclusion

There is a sound and robust case to be made for a valid and necessary place for caring, as an ethic of care in decision-making in the discipline of bioethics.

The case is revealed in its greatest strength in the accumulation of contributions from all of the disciplines involved in this study. These contributions come

predominantly from the disciplines of nursing, feminist theory, and medical ethics, that have been the main focus of this study. However, important contributions also came from the other disciplines of biology, anthropology, psychology and philosophy that have been included to a somewhat lesser extent in the study. Each of the three main disciplines contributed a distinct substantial part of the case, with nursing and feminist theory playing a rather more predominant role than bioethics, in this particular conclusion. Together with the added support of the other disciplines, a very strong multidisciplinary case in support of a place for caring in bioethical decision-making was created.

Summary of the disciplinary contributions to the case and the particular role each played.

The nursing contribution

The discipline of nursing provided a perspective of caring from a professional practise discipline in which caring is ontologically basic and fundamentally valued both generally and ethically in its constitutive practices of care. From an examination of practice narratives from nurses' experiences within a range of nurse-patient relationships, examples from the work of Benner (1984) provided a meticulously detailed and intimate account of the exquisite skills, intellectual, emotional, spiritual, and practical that were revealed in her studies of expert nursing practice. These accounts, if read, provide clear evidence that in this situation, caring is a complex, intricate skill, a consummate blend of the art and science of nursing, woven into ethical practices of care directed towards the purpose of being with and assisting human beings in their experiences of health, illness and dying.

The ethical nature of caring in nursing practice is demonstrated by examining Gadamer's view of practice as "human action directed by communal ways of being, aimed at promoting human good" (Gadamer as cited in Bishop &

Scudder, 1990, p73). In the work of Benner (1991) she demonstrated how nurses develop expert ethical comportment from reflection on an accumulation of past practical experience. This includes experiences of doing worse and doing better, from observations and emersion in practice, and contact with excellent role models and mentors. According to Benner (1991) the dominant ethic found in stories of everyday practice is one of care and responsibility. It can be seen then, that nurses caring practices involve deliberations and preferences guided by a perspective of care, because from their practical knowledge (practice wisdom) they have learned to actively value, trust and prefer (and so choose) caring. This is because for them, in their nursing practice it has demonstrated a primal relationship to "the good". Benner (1991) encompasses this in her definition of nurses' ethical caring practices as skilled actions "that have a notion of the good embedded in them because they are lodged concerns lived out in a community with a narrative tradition" (p.2).

The involvement of nurses in a community with a narrative tradition is an essential part of how nurses' support and sustain each other and their ethical practices of care. This together with the more general enculturation process of the nursing education process from undergraduate onwards, and the very important experiences of participating in the growth, development and healing of their patients, all serve to support sustain and re-enforce nurses commitment to caring ideas and ideals. This is important because nurses' ethical caring practices are often carried out in situations of uncertainty, difficulty and emotional tension. With the patient and their needs as the centre of their focus nurses frequently find themselves in situations of conflict with their employer, with other healthcare professionals (most often physicians), their patient and sometimes their own perspectives and needs.

This situation has been pointed out by Yarling and Mc Elmurray (1986), and is a point of tension and conflict between the nurses and feminist perspectives of caring. This is because one of the negative aspects of caring from a nursing

perspective in the view of the feminist perspective is that they see the position of nurses and their caring practices subjugated under the medical profession which to the feminists implies that nurses caring practices may be products of patriarchal exploitation and oppression of women's caring practices. Even if this is so, to whatever extent, abandoning caring and an ethic of care is not the answer. Rather the point is to find ways to avoid mitigate or remove the problems and traps.

Another very important aspect of nurses' ethical caring practices is that because of the nature of the nurse patient relationship it can be seen that even the small ordinary day to day decisions are ethical. This perspective implies that nurses' ethical caring practices are a way of being, or as an ontology and not something produced in an ethical dilemma or problem solving situation. Benner (1991) was the first to highlight the importance of skilled everyday ethical comportment in nursing caring practices. She sees nurses' everyday decisions not as separate from dilemma or quandary ethics but as providing the essential foundation for addressing the quandary and procedural ethics or issues. Benner also sees that "… quandary and procedural ethics depend on everyday skilful comportment and practical moral reasoning that is formed by the particular knowledge of the embodied knower". (p 1).

Despite the detailed account of nurses' caring practices and the mechanisms in nursing with which it is supported and sustained there are real difficulties that impinge on nurses' ethical caring practices which mean that despite nurses' best abilities the combination of external employment and social influences sometimes impinge significantly on their ability to be moral. It is here that a fruitful connection and dialogue with aspects of feminist theory could help. Some nurses have already and for some time been working in this area (see the works of Chinn and Watson, for example).

The feminist contribution

The contribution from feminist theory comes from a very different perspective. It is a plurality of views that are unified by " an attempt to uncover the ways in which conceptions of gender distort peoples view of the world, and to articulate the ways in which these distortions …are hurtful to all" (Little, 1996 p. 2). The feminist perspective acknowledges the tension between individual and community needs, and seek to include all voices. In general they contribute a perspective that is more broadly social and political and not confined by professional or social mandates. Even though, or perhaps because of, the assumptions at issue are often subtle or so familiar as to be invisible the "distorted and harmful conceptions of gender have come to affect the very ways in which we frame our vision of the world, affecting what we notice, what we value, and how conceptualise what does come to attention "(Little, 1996 p. 2).

Focusing specifically on caring and caring practices Little (1996) explains how the association of women with caring and what is seen as the natural and more basic processes of life devalues women, caring and nature in a perpetual circle of devaluation by association. Tronto (1993) identifies that caring is able to occupy a paradoxical position of being vitally important to human life, while at the same time it is devalued and compartmentalised. She explains that caring as a four-stage process is divided into two parts, where caring about - recognising need, and taking care of - recognising that action can be taken are related to broader public issues and roles, and seen as duties of the more powerful. The second part care giving - the direct hands on meeting of needs, and care receiving - the acceptance and response to the care delivered are related to more private issues and private roles, and are seen as duties of the less powerful. Tronto also points out that race and class, as well as gender determine who does caring and care work. These values and social structures are supported by social myths regarding people as autonomous, equal and independent. In the

feminist perspective people are never autonomous in the absolute sense, are not all equal, and exist in webs of interdependent and at times dependent relations.

These myths seem to be connected to a perception of care as posing a threat and fears of being overwhelmed that result in attempts to deny and denigrate caring. Miller (1976) sees these attempts to deny what are vast areas of life actually builds an exceedingly restricted conception of the total human potential. She points out that feelings of vulnerability and weakness are a natural part of human life. They are a necessary part of experience and growth, no one is exempt and they are not simply traits of dependent women. However. Miller further explains that, because women generally have a closer connection with this central human condition, and by having to defend less and deny less they are in a position to understand weakness and vulnerability. This understanding can be a positive strength. Finally Miller explains that caring as a fundamental part of participating in the growth of others, which has been in her view unfairly distributed to women, has the benefits of providing the pleasures of close connection with physical and mental growth, something that all humans can enjoy and benefit from. She is careful to point out that many of these situations are changing, but that process is not consistent in speed or distribution, and that what has not changed is that women have had to do this major work without the supports a culture would give to a task it valued.

That there are negative aspects to caring is fully acknowledged in the feminist perspective. According to Bowden (1997) seeing caring only in a positive light glosses over the dark side of it where caring practices have frustrating demeaning and isolating dimensions to their routines. Bowden notes that some feminist theorists see women's caring as a coerced practice on which their survival depends, and which may undermine their integrity and ethical agency perpetuating the reign of the dominant by encouraging self-sacrifice. Bowden explains that where the association of caring with women has been seen as natural, that is as an essential, inherent part of being a woman, correlatively, the

absence of caring attributes are used to castigate and denigrate women. She further emphasises that the essentialist association of women and caring results in the constriction of the enormous diversity of women's caring practices into abstracted and prejudiced models of femininity and care.

Finally Bowden along with Baier (1995), Carse (1991), Groenhout (1998a), Held (1995), Little (1996), and Miller (1976) agree that the compartmentalisation of the stereotypical women and caring relationships to the private realm of domestic, personal, and intimate relations reinforces the traditional splitting of public and private realms, and between men's and women's caring possibilities. While it is important to face up to the negative aspects of caring, it should not be dishonoured or abandoned. The value placed on caring by so many is not misguided. Rather, means to avoid traps and to remove distorting barriers need to be found, and similarly, means to support good caring practices need to be developed.

Exploring the ethical possibilities of caring is a potential source for good caring practices. As Noddings (1984) points out, the natural inclinations to do good present in human beings needs to be built on. It was the works of Gilligan (1982) and Noddings that initiated the development of an ethic of care, arising out of their dissatisfaction with traditional justice based principled theories of ethics and bioethics. Although some readers of Gilligan's work have taken the difference in the moral voices as gendered in an absolute sense, Gilligan did point it was by theme only that she detected the different voice. Further to this Friedman (1993) points out that despite any gender difference, the different voice hypothesis would survive because it reveals the traditional single-minded focus on abstract principles based on justice and rights as the only approach.

Johnstone (1994, 1999) explains that the main disagreements of feminist thought regarding traditional ethics and bioethics is that, the traditional approach is too abstract to be practically useful. It focuses too intensely on rules and principles

rather than promoting quality relationships between people. Finally it has tended to privilege the interests of white, middle class, able bodied, heterosexual males. From the work of Gilligan (1982) and Noddings (1984), and with some development within feminist ethics an ethic of care was created. It can be described as an ethic that recognises that the main moral concern is with needs, and a caring commitment to respond to those needs. An ethic of care recognises the inseparability of persons and their environments making choices contextually bound, and dependent on the particularities of the situation. It values and supports connections and relations between people, and values the natural interdependent relatedness of all human beings (Cleary, 1999).

A further important contribution to the case for a place for an ethic of care in bioethical decision-making came from feminist ethics. In Chapter Six two of the main objections and arguments put out in the bioethical discourses against a place for an ethic of care in bioethics have been picked up and addressed comprehensively and meticulously. First predicament is the dichotomous view perpetuated of an ethic of justice very tightly framed as focused on the rights of independent, rational, autonomous that are determined from an abstract impartial point of view (Held, 1995). While on the other hand, an ethic of care is tightly framed as focused on the response to the needs of persons who are seen as interdependent, and as existing in contextually bound, historical and particular relationships (Gilligan, 1982).

The predicament here is that the dichotomous framing is not helpful in progressing past and either/or position for an ethic of care and an ethic of justice. According to Clement (1996) resolution of this dichotomy is important because the ethic of care and the ethic of justice are " more fundamental that other possible ethics because they thematise two basic dimensions of human relationships …the ethic of justice focuses on questions of equality and inequality while the ethic of care focuses on questions of attachment and detachment, and both sets of questions can arise in any context" (p. 1). Further

to this as Gilligan has written "both inequality and attachment constitute grounds for moral concern since everyone is vulnerable both to oppression and to abandonment " (Gilligan as cited in Clement, 1996 p.1).

A second less directly oppositional approach to the justice care debate, according to Clement (1996) is the assimilation of the ethic of care into a justice perspective. This is an approach adopted by many traditional moral philosophers. Their position is that an ethic of justice can accommodate an ethic of care's concerns. In response to this assimilation approach Clement points out that an ethic of care studied from a feminist perspective has brought out critical attention to the gender coding of our moral concepts, and it has clarified and challenged sexual division of moral labour. She is emphatic that assimilating care into the ethic of justice cannot be done in a way that gives care equal status to justice.

Carse (1998) also defends a place for an ethic of care in bioethics in its own right. She presents an argument against the claim by bioethicists that a commitment to impartiality in principlist thinking does not, in and of its self- rule out the possibility of acknowledging special obligations, duties and relationships. However Carse, points out that, it is putting care into a principled frame which conflicts with the understanding of agency in an ethic of care where " moral judgement, can be generated by direct response to another, without any guidance or mediation of categorical considerations" (p.157). Carse is careful to point out that this does not mean that every moral response (in an ethic of care) is "a seat-of-the-pants response"(p158).

What is remarkable about an ethic of care is that it sees different features of cases as morally relevant, and it also pays attention to differences. Where as, the process of principle based abstraction exerts "normative pressure in the direction of attending to commonalities rather than difference"(Carse, 1998, p.166). Despite her strong argument in challenging the impartialist perspective,

Carse cautions against ignoring completely the nature of impartiality or adopting too limited a conception of the role principles can play in moral deliberation and response (1998, p.166),

In her detailed and meticulous examination Carse (1998) has shown that there is a reasonable amount of flexibility in the focus of impartiality in the ethic of justice. This eases it away from a totally oppositional position, which gives hope to possibilities for connection. Meanwhile at the same time, Carse (1998) has clearly demonstrated that an ethic of care really is a new approach to ethical deliberation, and not a re-representation of something already in existence. She has also demonstrated that in its very complexity an ethic of care contributes a valid and valuable approach not currently provided for in contemporary bioethics. In both non-feminist and feminist writing the ground work is now being established according to Clement (1996) for progression from a dichotomous view of the justice and care ethics to the recognition and exploration of the possibilities of some form of integration of the two.

The relationship between autonomy and care is the second predicament to be addressed meticulously from the feminist perspective. Autonomy is a powerful concept in Western society but its reign does not necessarily extend beyond the boundaries of that tradition. The concept of autonomy is deeply entwined in our personal understanding of freedom and who we are as human beings. However the liberal justice conception of autonomy focused on atomistic individuals as the basic units of political and legal theory fails to recognise the inherently social nature of human beings (Nedelsky 1989). As such feminist theory and ethics find it difficult to accept and would prefer to reject the liberal justice conception of autonomy. However Nedelsky is careful to point out that "no one among the feminists or communitarians is prepared to abandon freedom as a value, nor, therefore can any of us completely abandon the notion of the human capacity for making ones own life and self" (p.8). Nedelsky (1989) goes on to explain that "Indeed, feminists are centrally concerned with freeing

women to shape our own lives, to define who we (each) (emphasis original) are, rather than accepting the definition given to us by others" (p.8). This tension is the first part of the pivotal situation.

The second part is that feminists themselves are divided on the value of autonomy, and at the same time they are also divided on the value of an ethic of care. Restating for clarity Clement's (1996) explanation from page 160

> *There are important connections between these two debates. Many feminists who reject the ethic of care do so because they believe it undermines some notion of autonomy. For instance, whereas an autonomous individual defines herself, it is argued that an adherent of the ethic of care allows herself to be defined by others-by those for whom she cares. Similarly, those who criticise the notion of autonomy often do so because they believe it is inconsistent with an ethic of care…based on the recognition that human beings are socially constituted (p.21).*

In this view the liberal conception of autonomy emphasising individuality, is incompatible with an ethic of care. According to Nedelsky (1989) the problem is how to combine the claim of the social constitutiveness of social relations with the value of self-determination. She eloquently concludes

> *liberalism has been the source of our language of freedom and self determination. The values we cherish have come to us embedded in a theory that denies the reality we know: the centrality of relationships in constituting the self (Nedelsky, 1989, p.9).*

For an ethic of care to have some possibility of a place in bioethical decision-making, from a bioethical perspective, the apparent incompatibilities between the liberal understanding of autonomy and an ethic of care need to be addressed. However that is not sufficient in-itself, the tensions and divisions

within the feminist perspective on an ethic of care and autonomy also need to be dealt with in an acceptable manner in order to strengthen an ethic of care's case for a position in bioethics.

In Clement's (1996) view it is the portrayal of the ethic of justice and the ethic of care as ideal types that hinders reconciliation of care and autonomy, which she further points out are both flawed in important ways. However again, a reconciliation of the two is important according to Clement because

> *Autonomy (properly defined) serves as a criterion for an adequate ethic of care. That is unless a version of the ethic of care allows for the autonomy of the caregiver and the care recipient, the ethic of care will be deficient on moral and on feminist grounds (p.21-22).*

She explains that there are two general categories of impediments to psychological autonomy in the usual liberal view. It is understood as having a negative component to not be coerced, and a positive component to critically evaluate one's choices. Clement (1996) points out that critical reflection is itself a social product, and that this realisation has made many philosophers seek for ways that an individual can elude his or her socialisation and thus be autonomous in the ideal conception. However, she emphasises that although no one can escape his or her socialisation, it is obvious that some people are more autonomous, that is, in control of their lives, than others, and that we can recognise that critical reflection allows people to be more autonomous than they would be otherwise (p.23-24).

The results of this thinking according to Clement (1996) present two approaches to the question about social constitutiveness and autonomy

> *On the one hand, we can define autonomy and then consider whether anyone achieves it. On the other hand, we can observe the differences between people we*

consider autonomous and people we consider non autonomous, and then make
generalisations about what constitutes autonomy (p. 24).

If it is the conditions that allow individuals to be as in control of their lives as they can be that is important, then social conditions obviously have a role, and we need to expand our standard accounts of autonomy. Two major features need to be recognised, first we learn to become autonomous not through individual isolation but through relationships with others. An individual's autonomy is nurtured through the care of others (Clement, 1996). Further to this she is careful to point out that some relationships foster these skills better than others and some relationships actually undermine these skills. "But relationships, and specifically caring relationships, are a necessary precondition for autonomy" (Clement, 1996, p24). The second feature is that one need not be coerced in that one is literally forced to do someone else's bidding, social and relational circumstances can have this effect without the literal force. What needs to be recognised at this point, are the culturally bound norms and sanctions that are part of the social factors that have such influence on how people live their lives.

There are definite possibilities for reconciliation of care and autonomy if we include the understanding of these features in an expanded account of autonomy as Clement explains doing this

eliminates the excessive individualism that conflicts with the ethic of care. It also
allows us to focus on the core of the feminist criticism of the ethic of care, namely
that it serves to disempower women… but the notion of autonomy I defend
would certainly not conflict with being a caregiver, instead it would seek to
empower caregivers by demanding that they have the power to carry out their
responsibilities adequately. (Clement, 1996, p.26)

Further to this Blum, Homiak, Houseman and Scheman as cited in Clement (1996) emphasise

> *Concern, care, and support may be defective unless they are founded on a strong sense of autonomy or independence and a healthy concern for oneself, so that in some sense a genuine and non-defective care actually requires autonomy (p.27).*

What Clement (1996) and to a lesser extent Nedelsky (1989) have demonstrated and contributed to the case for a place for an ethic of care in bioethics is that, it is possible to close the division in the feminist perspectives on an ethic of care, and less fully developed but still a possibility, to quiet at least some of the criticisms of bioethicsts and other non feminists opposed to an ethic of care. Reconciling care and autonomy according to Clement requires moving beyond the ideal types of autonomy and care, and examining different versions of both for compatibility to find the right balance between the connections and the separations between individuals.

The bioethical contribution

It might seem odd to talk about a contribution from bioethics in support of an ethic of care having a legitimate place in the discipline, however it does make one. And it comes from two different aspects of bioethics. First, not all bioethicists or physicians are against an ethic of care. From chapter four, Pellegrino, (1993) outlines the parallel development of moral philosophy on the one hand and medical ethics particularly in relation to the ancient but durable Hippocratic Oath. The Hippocratic Oath contains within it, the seeds of care and virtue inherent in the practice of medicine, and physicians in the present with the focus on market oriented health solutions are discussing the effects this has on their own ethics. In this, it is not so much that even concerned Physicans like Pellegrino (1993) and Thomasma (1994) actively embrace an ethic of care as espoused from the feminist or nursing perspectives, but in their questioning and doubts evidenced in the bioethical discourses there lie possible seeds for

connection if interdisciplinary dialogue can be fostered more regularly and respectfully with nursing and feminism.

The second contribution is also less than direct and stems from the critique of contemporary bioethics, by bioethicists presented in chapter five. In their critique of the use of the principle based approach only, they share points of common ground with both nursing and feminist theory and ethics in what they find most objectionable about using principles in clinical practice with real people and real lives. Although there are points of connection, they do not take the step of actively embracing an ethic of care as proposed either. Their own proposed alternatives skirt close to it using terminology and language that almost suggests they mean caring but never quite cross the line. However, once again in their questioning and critique there lie the seeds of connection. The question is who will make the first move and how will they go about it.

In summary of the summary, It can be seen that there is a clear and unequivocal case for caring as an ethic of care to have a valid and respected place in decision-making in bioethics. However in the course of the study two broad but important factors that can and do impinge on these possibilities have surfaced. The following is a brief discussion of each that due to time constraints I have not been able to polish to the required standard.

The constraint of caring dialogues in bioethics
Within the discipline of bioethics, bioethicists and medical physicans, who by far make up the most frequent, and greatest number of contributions to the disciplinary discourse, dissent as to what constitutes the most effective approach to ethical situations. As seen in chapter five they put forward casuistry, narrative ethics, and virtue ethics. Some even put forward the idea that it needn't be brought down to one choice that all those named could have a place in a plurality of approaches. Aspects of caring were addressed by some bioethicists and physicians, for example in Lawrence Blum's defence of moral

aspects of emotions and feelings being necessary in order to be ethical, and MacIntyre (1984) explored virtue and Pellegrino (1993) emphasised virtue and caring as important aspects of medical practice. However since the formation of bioethics as a discipline and despite the well documented dissent and disfavour of the principle based approach particularly in the clinical encounter and the alternatives sought for and variously developed, caring as an ethical approach in itself, was never put forward by bioethicists or physcians. An ethic of care as a viable approach to ethical situations arose out of the development of feminist ethics as noted in chapter three.

As feminists turned their gaze on to ethics and healthcare ethics in particular they saw that according to Browning Cole and Coultrap-McQuin (1992) that although women and their values are of profound importance they were ignored in bioethics. Social institutions and practices in general encouraged discrimination against women and the suppression of their moral views; and finally, that these two assumptions have led to demands for a new ethical outlook as well as for social change. The feminist perspective though concerned with women's issues and experiences also recognises the involvement of race and class as well as gender as issues to be addressed. It has also been made clear in feminist studies, that the restrictions of bias and discrimination placed on women in our society in effect lead to corresponding restrictions on men also. Thus changes to the bias and restrictions of gender would be seen to benefit all members of society.

Women make up the greatest numbers in caring work domestically and in healthcare, and also significant in terms of the relationship between bioethics and health, is the fact that women comprise at least half of the population that requires healthcare. At the philosophical and theoretical levels, the actual nature and significance of the role of gender continues to be a matter of active debate in contemporary moral thinking. On a more practical level, and to state the obvious while avoiding getting into the sameness/difference debate at this

point, the human race is made up of roughly equal proportions of the female and male genders. These female and male persons have at least some health and healthcare issues that specifically relate to their gender both biologically and socially at some point in their life span. The manner in which these health and healthcare issues are handled has important implications for bioethics. Thus in considering the place of caring in bioethics gender is undoubtedly an important issue. The gendered association of caring with women and private and personal, is a barrier to seeing and understanding the real value of caring to human beings, men women and children, their ethics, society, quality of life, and survival.

Nurses, as they developed their own ethics as distinct from those of medicine, under which they had been suppressed and subsumed for most of the disciplines history, also voiced discontent with principle based ethics as the approach to use in their ethical decision making. Nurses also because of the fundamental place of caring in their practice supported caring as important and ethical in nature. However the ethic of care as developed in feminist ethics was not uniformly considered appropriate to be adopted into nursing ethics.

Initially in the strong drive to separate themselves from medicine and stand on their own as a professional discipline, emphasis was put on professionalism and the scientific approach in education practice and research order to attain credibility and acceptance of their independence. Being aware that their caring skills were seen as unscientific, and undervalued as simply part of women's expected work (whether in nursing or in the home), many nurses felt that to embrace an ethic of care would not be helpful to the cause of establishing their legitimate professional independence. Thus the vision of nursing as an ethical caring practice was not so much lost as submerged in the drive for independence and acceptance for a time, and only in some areas.

More recently on seeing the impact of technology and economic and political policy, in the Western world, on themselves and on the people they care for the need for human caring to redress the dehumanisation has become of prime importance (Watson, 1990). There is a strong move to make visible explain and support the valuing of the complex caring skills developed by nurses in order to foster healing and health in their patients. Nurses like feminists have explored what traditional bioethics has to offer and explored the more recent proposed alternatives and have come out in the present stage of development of their discipline and in support of caring to embracing an ethic of care (which some say as always been a characteristic of nursing practice). Nursing has its own ethical journals and in those and other nursing journals lively debate seems to coming towards the acceptance of an ethic of care along with accepting a range of other approaches from within bioethics such as virtue ethics and principle based ethics which are recognised as useful in education and in the development of nurses from the novice stage up to the experienced level. Thus nursing seems to developing the notion of a sort of eclectic ethical tool kit if you will.

However, conversely, within the discipline of bioethics, an ethic of care has been treated with deep suspicion if it was acknowledged at all, and discussions have been confined to occasional articles in bioethical/medical ethics journals, and two whole issues of the journal "Medicine and Philosophy" one in 1990, and one in 1998. And as if they indeed do not "see" caring, the bioethical disciplinary discourses continue to search and debate what is the best approach amongst both the old and new alternatives but not including caring or an ethic of care.

Perspective and socialisation
The position of caring in society is deeply and widely entrenched and is not going to change quickly or easily. (Tronto, 1993) It is so embedded and kept invisible (Benner & Wrubel, 1989; Bowden, 1997; Watson, 1990) which makes it difficult for people to recognise consciously that it requires more attention

which is the first step to change. It is like in an addiction problem where first step is recognising there is a problem, feminists and nurses have done this but most bioethicists and physicians, have not. In the larger context outside the healthcare arena the main social, scientific, economic and political systems are still very gendered, Cartesian and positivist. These influences have a powerful and enduring effect on perspective, and the ability to see differently. If people are not presented with many different views as they are developing and growing it often takes some major occurrence to be able to jolt open the perspective to seeing differently, or the need to do so.

When Wittgenstein referred to the fact that "we tend to be blind to the things most important to us" It makes one wonder how much of that is to do with what we have been socialised and trained not to see. And purely speculatively how much the fear of vulnerability and weakness attached to caring and needing care and the psychological adjustments made to cope with those fears, particularly resting here on Chodorow's (1978) view of the different gender developmental processes of girls and boys, effects that blindness and inability to "see" caring. It seems to me that the way we socialise children the way they acquire gender identity may have a role in the process of developing basic ways of seeing that may become narrowed and entrenched perspectives.

The statement that we cannot come to know and understand what we do not see actually may hold some hope boys and girls can and do experience caring do know what caring is can see it and feel it from their earliest experiences in life up to when the developmental separation point is reached. If one were to take an epidemiological approach to the perpetual socialisation cycle, this early stage would seem most promising to break the cycle and intervene. Studies have shown that gender attributes are acquired very early in life thus here is the place to find ways to study and analyse just what we pass on to our children that contributes to those differences and which are acceptable and life enhancing for all and which are not. As for example the male fears surrounding

dependence and interdependence and the need to deny the common human need for caring resulting from the too strong separation from the female figure in order to become the socially constructed idea of what it is to be a man (Chodorow, 1978) and similarly in case of the female where up until the recent past they came to see themselves only defined within relation, resulting in some cases in the socially constructed dependent woman (Miller, 1976). This neatly fits with the socially constructed ideal of the nuclear family-strong independent male head of the house, together with a dependent caring female to provide for needs of man and children.

This is undeniably changing, but then even if or when the need for change is seen, steps towards that change are often slow and need to be supported and nurtured. This requires resources and time that in turn requires economic and political backing which is still male dominated and pervasively threaded through and through with Cartesian and scientific dualist abstract and impartial thinking. This is not to say that there aren't men who do see and wholly support the need for change and aren't diligently working within governments and economic systems towards those changes. However they remain in the minority and to the extent that they are perceived to align with a female caring perspective they too are often marginalized and their efforts also rendered less effective in the change process.

Thus the place of caring and any ethic developed from it, despite having a very thorough and well supported research based case put forward by feminist theorists and nursing scholars and theorists, for its inclusion as a full and equally worthy approach to dealing with ethical situations arising in bioethics (or ethics in general), remains constrained and marginalized in a corner of the discipline of bioethics. This is despite the fact that through the evidence presented in the chapters of this thesis that those who support the inclusion of an ethic of care has effectively demonstrated their awareness of the negative

aspects of caring and have answered each criticism levelled at it eloquently and effectively.

The limitations and an evaluation of the study

At the beginning of this study I was on a quest to understand more clearly than I did at that time, what place caring may have in bioethics. My initial impetus came from a paradoxical experience of personally and professionally valuing caring and an ethic of care, while attending a multidisciplinary bioethics conference, where few others there knew of, let alone valued, an ethic of care in bioethical decision-making. The experience was even more acute in that "the costs of caring", was the focus of the conference. Using the difference between what I knew about caring and bioethics at the time, and what I wanted and needed to understand, I made the critical decision at this basic level of an initial exploration of a topic, to stay with a very broad approach in this study. This was in order to cover and allow maximum exposure to a wide range of information. From this position came the decision to not adopt a specific research methodology, in terms of selecting phenomenology for example, but to stay virtually at the level of the literature review stage of a research project, and literally immerse myself in the literature concerning caring and an ethic of care in bioethics. This was done with the questions in mind, what is going on here? I understand caring and an ethic of care to be a valuable, vital and most importantly an ethical part of nursing and healthcare, therefore, in a situation where the implications of the financial aspects of caring, were being discussed from a bioethical perspective, why was caring or an ethic of care virtually absent, or only mentioned in a dismissive manner? What place should or can caring really have in bioethics? The next step was deciding to include literature focused on caring and an ethic of care from the disciplines of bioethics, nursing and feminist theory and the study actively began.

The choice to stay broad and immersed in the literature is an accepted valid approach when beginning to explore a topic (Rountree & Lang, 1996). I took this choice because the areas of nursing ethics, an ethic of care, and ethics in general are important and of particular interest for me. I intend to use this broad study as a beginning point for future work in this area However, in taking the broad view, it proved quite difficult, though not impossible, to handle, organise and keep track of the literature especially coming from three different disciplinary perspectives. I spent a long time "out there" with the literature, and at times lost my direction and perspective completely, "coming back" and making coherent sense of it all was a very long difficult process only able to be achieved in episodes. This experience is part of many research processes and not unique to my study, but if I had chosen a clearly defined methodological approach the process may have been more structured, concise and (only perhaps) less arduous. I have no wish to claim the sufferer's crown!

Initially in the data-gathering phase of the study I concentrated on online databases and peer reviewed journal articles listed in them. I used bioethics but the responses for articles involving caring and/or an ethic of care, were not large and did not satisfy my personal criteria for richness and depth in all of the disciplines. The next step was physically going to the libraries accessible to me and tracking down the actual articles. This solved the problem of sparse numbers from the databases and provided a richer source of information, in that within the same issue and amongst other issues that I browsed I found many more relevant articles. I also came across books. Unfortunately this undermined a clear approach to the literature in terms of crisply defined parameters to refer to. However, on the other hand serendipitous "finds" led to satisfying depth, richness and connections being made that otherwise would not have occurred. On reflection and in balance I feel that my choice of approach, and process of study development achieved my initial aim of exploring the possibilities for a place for caring (as an ethic of care) in bioethics,

and did also provide a sound case for it to have a valid and valuable place alongside other accepted approaches to decision-making in bioethics.

The significance of the study

The significance of the study is that, in taking the chapters and the disciplinary contributions and critiques together as a whole, a robust case has been created for the ethical importance of caring and an ethic of care. It is a case that soundly and meticulously supports a valid and respected place for caring as an ethic of care in bioethical decision-making. The case rests predominantly on strong evidence provided from both the disciplines of nursing and feminist theory. Each had a distinctive part to contribute, along with a combined contribution from the areas of commonality and compatibility between them. The key is that the whole case is only revealed through the combined interdisciplinary picture, which leads one to question what further interdisciplinary study and communication could achieve.

The implications of the study

Relevance to nursing
Caring is fundamental to the discipline of nursing, so much so that it is assumed that caring is a way of being or an ontology for nurses. Thus anything that effects the valuing and perception of caring is relevant to nursing. The fact that caring is also seen as an ethical entity adds to the importance of the commitment and attention nurses pay to caring. If caring is not seen, a large part of nursing, indeed the heart of it, is missing. Nursing is also invisible if the ethical aspects of caring are not accepted and valued because then a nursing ethic based on, or including an ethic of care will have no or less power and credibility. It will not help nursing's ethical voice to be heard

Having a nursing ethic and our own journals is necessary and important but the ethical world that nurses inhabit is multidisciplinary and also contains different

spheres and levels of action and responsibility we need to be able to participate in ethical discussions in all these areas, this will entail being multi-perspectival, and having an awareness of what in any situation is gender based what is different paradigms or individual differences, what is management or organisational system problems and what is clinical. This in turn has implications for nursing education While waiting for the larger social changes to occur nurses need to look for points of connection with others involved in patients experiences in healthcare system. This means getting experience in inter-professional and interdisciplinary dialogue. The key is how others do or do not perceive caring and that in turn depends on so many things social cultural and biological that is an enormous task to attempt to influence the process of how people come to know about and form an understanding of caring . Gender obviously plays a part but it is not all that has an influence, and indeed given that caring is a human need, common to all, although gender is without doubt significant and must be addressed, it may also overly divert attention from searching for solutions based on commonalities and points of connection rather than points of difference.

Reflection

This has been an enormous learning experience. The aims I started out with changed and at times got lost in the sheer volume of information I encountered and tried to take in and organise into a coherent view. I overreached my self in what was appropriate and possible in a two-paper thesis. And I also over reached my own abilities as a novice in taking on this type of study which I thought initially was in the manner of a major literature review, but in hindsight was a raw and ungainly novice attempt along the lines of philosophic enquiry. I have a personal predisposition to broad thinking and making connections and attempting to see the whole picture from many different angles.

According to Carper (1979) philosophic considerations of nursing and of the impact of social forces on the activities of nursing differ from the empirical investigation that acts as an end product of investigation to add to what is known. The objective of philosophic enquiry is not to extend the range of what is known but rather to form a way of critically examining or thinking about what is taken to be of valuable or significance, in this case, to the nurse engaged in the enterprise of nursing. (P. 2). In my very humble view, at the end of this study this seems to be close to what I have been doing Carper (is 1979) states that in thinking philosophically, I am concerned with carefully suggesting or constructing a guide to the practical activities of nursing by becoming critically aware of what is involved in the complex business of nursing. (P. 2).

By no means am I at this stage, but this study with its required emersion in the literature of bioethics feminist theory and ethics and nursing theory and ethics has given me the beginnings of the broader picture regarding the position of care and an ethic of care in relation to all three disciplines. It has also given me an idea of the size of the project of establishing it firmly in ethical decision-making. I remain true to my original assumption that ethical decision-making is not truly ethical without including the perspective of an ethic of care at the end of the study, if not even more reinforced and reenergized by the picture of the possibilities of the place of caring in bioethics that has developed in my mind over the course of this study.

The future

Several important directions that can be pursued as a matter of course and as next steps or further studies and research projects, and this is far from exhaustive, are

- Continuing to support the values skills and knowledge of caring and ethical caring practices in my own work and life

- Working in the area of finding what processes are used to teach ethics at undergraduate level developing them to enable nurses' voice and ability to participate in ethical discussion from the stand-point of their own ethic and ethics

- Where able to foster interdisciplinary dialogue when ever possible

The project is of course huge and of course it is not my intention to assume any kind of definitive direction or answers. But what I will be doing is continuing to think, read, talk and research in a purposeful manner to contribute to acknowledging the valuing depth of skill and ethical capacities of caring in ethical decision making.

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