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**REFRAMING THE ETHICS OF CARE: IMPLICATIONS FOR MORAL EPISTEMOLOGY
IN BIOETHICS**

An honors paper submitted to the Department of Classics, Philosophy, and Religion
of the University of Mary Washington
in partial fulfillment of the requirements for Departmental Honors

Lukas E Chandler

April 2016

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REFRAMING THE ETHICS OF CARE:
IMPLICATIONS FOR MORAL EPISTEMOLOGY IN BIOETHICS

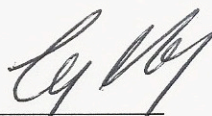
Submitted in partial fulfillment of the requirements for
Honors in Philosophy

University of Mary Washington
Fredericksburg, Virginia

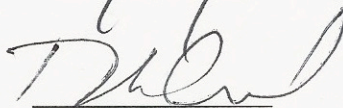
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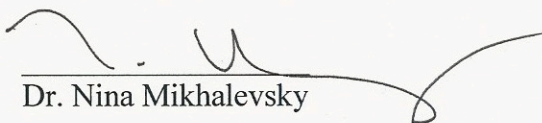
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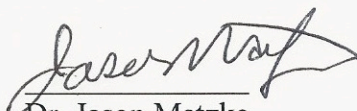
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1. INTRODUCTION: WHY AN ETHIC OF CARE?

The philosophy of biomedical ethics provides modern day health care workers, patients, and philosophers with a normative framework in which to make moral deliberations concerning the meaning of health and the meaning of a good life. The paradigm of justice has bound health care providers and patients to an approach that is premised on impartial abstraction and universal application of principles. However, many contend that this approach to biomedical ethics is practically flawed and limits the roles of health care providers to deliver adequate “care.” Namely, theorists defending a care orientation in biomedical ethics consider the justice approach to bioethics as undermining those efforts, which support patient autonomy, interpersonal relationships, and the development of caring attitudes in medical relationships.

The decisional responses of health care professionals in regard to their patients are often moral in nature insofar as the decisions these professionals make concern the ultimate essence of human mortality manifested in particular medical conditions. The locus of this essence can be found in the interactions of patients and health care providers.¹ What I am primarily investigating here is how the caring perspective develops and sustains these moral relationships in clinical interactions. More specifically, I am evaluating the strengths and limitations of both the caring perspective and a principlist instantiation of the justice perspective in biomedical ethics in order to review the theoretical implications of these perspectives for moral epistemology in medicine as well as their practical ramifications for the institution of health care. I argue that we need both care and justice perspectives in order to acknowledge the real inequalities (of knowledge, power, socio-economic status, race, gender, etc.) between health care professionals and patients. In this way, we may discover new avenues for employing our philosophical concepts to concrete and

¹ Virginia A. Sharpe, “Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics,” *Theoretical Medicine* 13 (1992): 307.

contextualized medical situations. The bulk of my analysis will involve thorough explication of Virginia Ashby Sharpe's "Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics." Sharpe's article reviews the two orientations and concludes that the care orientation is congruent with Dr. Edmund Pellegrino's theory of medical morality within the healing relationship between physician and patient. For Pellegrino, one of the essential questions to ask is what "should the relationship be of formal philosophy to medical ethics?"² Through my analysis of the ethics of care and its specific relationship to biomedical ethics, I will consider various responses to this question to support a richer and more diverse understanding of how we can respond to the suffering and needs of others within medical contexts.

² Edmund D. Pellegrino, "The Four Principles and the Doctor-Patient Relationship," in *The Philosophy of Medicine Reborn: A Pellegrino Reader*, edited by H. Tristram Engelhardt and Fabrice Jotterand (Notre Dame: University of Notre Dame Press, 2008), 197.

2. WHAT IS THE ETHICS OF CARE?

It is important to sort out what exactly is meant by an ethic of care, especially within the context of medicine and nursing where terms like “health care,” “medical care,” and “nursing care” are frequently expressed. This requires a brief review of the history of caring in the philosophical and medical traditions. In his *Encyclopedia of Bioethics*, Warren T. Reich explores many of the early roots of caring and the implications of these origins for contemporary care theory and bioethics. One of the earliest and most significant of these origins is the care of the souls tradition in ancient Greece and Rome. We find our common notion of “taking care of the whole person” embedded in the ancient concern of care for souls, both the internal experience of solitude and calling attention to suffering as a subjective experience.³ Suffering is experiential and subjective, so acknowledging the experience of the sufferer is the first step to caring for the greater “whole” of the person.⁴ Centuries later, Goethe constructs a narrative with his character Faust, illustrating how striving for success in one’s life while suppressing concern for others results in both internal and external harm.⁵ For David Hume, passions and moral emotions are the primary motivators for action and moral judgments are grounded in sentiments and not reason.⁶ During the development of existentialism and phenomenology, figures like Kierkegaard and Heidegger reformulated the fundamental question for ethics into “how should I live?”⁷ In the 1920s, “caring for” the patient became a more focused moral concern in health care with

³ Warren T. Reich, “History of the Notion of Care,” ed. Warren T. Reich, *Encyclopedia of Bioethics* (New York: Simon & Schuster Macmillan, 1995), 321.

⁴ *Ibid.*, 321.

⁵ *Ibid.*, 322.

⁶ *Ibid.*, 327.

⁷ *Ibid.*, 323.

increased interest in a virtue of care as the simple moral orientation to health care, based in feelings for the other.⁸ This shift in concern to “care for” the patient assisted in the redefining of ethics in medicine and roles of health care professionals amidst the high-rate of medical discoveries and technological developments, which often overshadowed the care of the individual. Finally, feminist perspectives on care during the 1980s produced a movement in which challenges in nursing and female perspectives in medicine were reevaluated. Problems in nursing, such as depersonalization of health care due to the fragmentation of specialized treatment, highly institutionalized bureaucracies, and the overshadowing of individual patient needs by a shift in emphasis to the technological process of curing are just a few of the problems that feminists, in particular, have recognized.⁹ Modern health care, especially the care of those who suffer, continues to face a vast variety of these challenges.

Carol Gilligan changed the conversation of “caring” in her book *In a Different Voice*.¹⁰ Gilligan’s contributions to moral psychology have major ramifications for the development of moral epistemology within the ethics of care. Feminists and care theorists frequently cite Gilligan and recognize her work as essential to the move away from the predominant ethical theories, like Kantianism, which as a result of duty-based priorities, have often neglected the particular concerns of concrete individuals. Some instantiations of deontological theories and justice approaches to ethics, such as Lawrence Kohlberg’s theory, portray women as morally deficient.^{11, 12} A key transformative question in how we approach medicine or suffering is not

⁸ Warren T. Reich, “Historical Dimensions of an Ethic of Care in Health Care,” *Encyclopedia of Bioethics* (New York: Simon & Schuster Macmillan, 1995), 334.

⁹ *Ibid.*, 335.

¹⁰ Carol Gilligan, *In a Different Voice: Psychological Theory and Women’s Development*, (Cambridge, Massachusetts: Harvard University Press, 1982).

¹¹ Sharpe, “Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics,” 300.

asking, “what is ‘just?’” but “how to respond?”¹³ Through her study of young girls and women, Gilligan located two different ethical orientations. Men tend to follow the justice orientation, where the focus on inequality is their main concern and women tend to follow the care orientation, where they focus on equality and personal attachment.¹⁴ This distinction of justice and care is my primary concern as it relates to concrete medical situations. Gilligan emphasizes the fact of our humanly interdependence between other individuals with specific needs and goals.¹⁵ Furthermore, this interdependence in care privileges responsibilities and responding to the needs of others.¹⁶

Nel Noddings’ model of caring builds on and expands Gilligan’s work in moral psychology. However, where Gilligan conceptualizes caring as moral reasoning, Noddings envisions caring as a practical activity.¹⁷ In *Caring*, Noddings states that, “to care may mean to be charged with the protection, welfare, or maintenance of something or someone,”

¹² Kohlberg’s theory defines morality not in terms of its content but rather “in terms of the formal character of a moral judgment” by emphasizing the traits of universality and impartiality. In taking the view that “morality is justice,” Kohlberg assumes a formalistic approach to ethics, which disallows us to approach morality on partial or relational grounds. Additionally, in Kohlberg’s study, men and women are afforded differing levels of moral maturity. For Kohlberg, women eventually fail to meet the standards of Kohlberg’s theory by focusing on individual interests. Gilligan considers this view flawed theoretically and empirically. For more on Gilligan’s dispute with Kohlberg, see Sharpe “Justice and Care,” 300-301.

¹³ Sharpe, “Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics,” 313.

¹⁴ Warren T. Reich, “Contemporary Ethics of Care,” *Encyclopedia of Bioethics* (New York: Simon & Schuster Macmillan, 1995), 337.

¹⁵ Alisa L. Carse, “Impartial Principle and Moral Context: Securing a Place for the Particular in Ethical Theory,” *Journal of Medicine and Philosophy* 23, no. 2 (January 1, 1998): 164-65, accessed January 16, 2016, <http://dx.doi.org/10.1076/jmep.23.2.153.8923>.

¹⁶ Margaret Olivia Little, “Care: From Theory to Orientation and Back,” *Journal of Medicine and Philosophy* 23, no. 2 (January 1, 1998): 192, <http://dx.doi.org/10.1076/jmep.23.2.190.8922>.

¹⁷ Reich, “Contemporary Ethics of Care,” 338.

demonstrating the qualities of receptivity, relatedness, and responsiveness.¹⁸ This charge certainly concerns health professionals and their responsibilities to patients. With just a brief introduction to the development of caring in health care, the justice-care distinction still requires some in-depth theoretical unpacking.

Ethical theorists and writers in bioethics often describe “care” or “caring” as a perspective, virtue, theory, orientation, or ideal. In their *Principles of Biomedical Ethics*, Tom Beauchamp and James Childress interpret the ethics of care as a form of virtue ethics insofar as it privileges the characteristics of interpersonal relationships.¹⁹ A virtue here is understood as a dispositional trait or feelings with a particular motivation(s), which signifies its belonging to virtue theory.^{20, 21} Virtues drive normative behavior and signify the moral praiseworthiness (or wickedness) of individual actions. Simply put, virtue ethics is concerned with sustaining a moral theory from character traits that enable and incline an individual to make the right kind of action.²² The general consensus among philosophers is that care ethics is a form of virtue ethics. This view is affirmed by Virginia A. Sharpe but dissented by Virginia Held, who offers a sharp distinction between the ethics of care and virtue ethics in which she attributes the former to

¹⁸ Sara T. Fry, “The Role of Caring in a Theory of Nursing Ethics,” in *Feminist Perspectives in Medical Ethics*, ed. Helen Bequaert Holmes and Laura M. Purdy (Bloomington and Indianapolis: Indiana University Press, 1992), 5.

¹⁹ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 7th ed. (New York: Oxford University Press, 2013), 35.

²⁰ *Ibid.*, 31.

²¹ I acknowledge that this interpretation of virtue ethics is disputed within the discipline. This view presupposes the claim that care ethics fits under virtue ethical theory. However, there are other competing definitions of virtue ethics. A stronger case can be made that asserts care ethics as a form of virtue ethics, which makes a more precisely Aristotelian account of virtue ethics. If you accept Hilde Lindemann’s account, care ethics will look more like virtue ethics. We can also ask the wider question concerning whether virtue ethics is a verison of care ethics.

²² Beauchamp and Childress, *Principles of Biomedical Ethics*, 378.

particular relationships and the latter to the dispositions of individuals.²³ At least for Held, “the central focus of the ethics of care is on the compelling moral salience of attending to and meeting the needs of particular others for whom we take responsibility.”²⁴ I think Held’s stance nicely encapsulates the general aim of care ethics: recognizing obligations to the other and attending to the needs of the others. Although some scholars question the epistemological status of care ethics in our moral deliberations, I do not believe that the debate as to whether care ethics is a genuine ethical theory or not is especially relevant to my aim here.²⁵ Nevertheless, the dispute of how to describe the two orientations significantly influences the ways in which they are understood and interpreted. At least for this thesis, I will use the terms “perspective” and “orientation” interchangeably to describe the ethics of care as defended by Virginia Sharpe.

With a more structured outline of the ethics of care, I think we may concretize our understanding of these concepts more effectively. Hilde Lindemann offers three general features of caring, which are helpful to conceptualizing interpersonal relationships premised on an ethic of care. First, there is the expression of a caring relationship. “Caring” is a moral term insofar as we can use it to guide our feelings and know when to act on those feelings as well as evaluate particular instances of caring.²⁶ Second, caring involves the “engagement with another’s will,” not merely treating them as an object. Instead, the one caring attends to a person with wills,

²³ Ibid., 57.

²⁴ Virginia Held, “The Ethics of Care as Moral Theory,” in *The Ethics of Care: Personal, Political, and Global* (New York: Oxford University Press, 2006), 10.

²⁵ Margaret Olivia Little argues in “Care: From Theory to Orientation and Back” that there is a distinction between orientations and theories. While a theory is a set of propositions (conceptualized narrowly), orientations, like the care orientation, focus more “in terms of emphases of concern and discernment.” She claims that the care orientation is not a theory but “a stance from which to do theory” and in this way orientations should not be equated with theories. See “Care: Theory to Orientation,” 195-196.

²⁶ Hilde Lindemann, “Feminist Ethics of Care and Responsibility,” in *An Invitation to Feminist Ethics* (New York: McGraw-Hill, 2006), 92-93.

intentions, and desires of her own.²⁷ In this way, the one caring must set aside her wills, intentions, and desires by acknowledging those of the one who is vulnerable or suffering.²⁸ Third, caring charges one to give attention to the particulars of context instead of being led by mere abstractions in moral deliberation.²⁹ These three features are certainly not exhaustive descriptors of an ethic of care. Other virtues or descriptors of care include the traits of sympathy, compassion, fidelity, and love in intimate personal relationships.³⁰ Later, we will see how emphasizing our attention to the particular idiosyncrasies of relationships is not entirely compatible with the justice orientation's moral emphasis on impartiality and universality. Indeed, the justice orientation is an inadequate ethical theory alone, for it neglects important specific and individual aspects of vulnerable persons by emphasizing impartiality. Nevertheless, this basic structure will guide us as we review the terrain of medical ethics and aim to bring greater attention to the caring perspective, which unlike the paradigmatic justice perspective, has often been neglected and underappreciated in conversations concerning patient-provider interactions.

2.1 Feminist Intersections with Care Theory

Contemporary care ethics has many of its origins in feminine and feminist literature. However, there is an important distinction to be made. In *No Longer Patient*, Susan Sherwin interprets "feminine" ethics as those observations of how traditional theories fail to include the

²⁷ Ibid., 93.

²⁸ I want to acknowledge here that I am evaluating the ethics of care within the context of medical ethics, so any dispositional trait aimed at caring will necessarily have to attend to some sort of metaphysical experience of pain or suffering. Though vulnerability may also designate the one who is cared for outside of medical contexts, like a child and mother or father, the particular vulnerability I emphasize in my analysis is the vulnerability of patients with certain conditions that necessitate caring responses. To be clear, a caring ethic in any context may certainly evolve to fit the needs of the individual giving care and the individual receiving care.

²⁹ Lindemann, "Feminist Ethics of Care and Responsibility," 93.

³⁰ Beauchamp and Childress, *Principles of Biomedical Ethics*, 35.

moral experiences and intuitions of women.³¹ For ethics to be valuable to the aims and embodied experiences of women, ethics needs to be modified so it ceases to neglect the voices of women. In a similar vein, “feminist” ethics recognizes women’s moral experiences but goes a step further. Feminist ethics is primarily concerned with the rejection and relief of the oppression of women.³² For Warren Reich, feminine and feminist ethics are interrelated as they share a common goal of including women’s voices in diverse fields of scholarship and research.³³ I bring this distinction to our attention primarily because I want to reveal the mistake of equating the aims of feminist ethics with feminine ethics. Although they share some common goals, this distinction enables us to consider the two as interrelated but distinct methods for care theorizing.

Feminist bioethics has many significant intersections with medical ethics, some of the most prominent being understanding of context and balancing inequalities within relationships. Feminist philosopher Susan Sherwin notes that, “medical ethics shares with feminist ethics a commitment to focus on context and an understanding of the significance of inequality within relationships, and some authors in medical ethics express a desire reminiscent of feminism to include caring values in their analysis.”³⁴ This is a relevant intersected issue in medicine. However, Sherwin also criticizes medical ethics. For Sherwin,

Given their shared commitment to focusing on context in moral problem-solving, their common understanding of the ethical significance of inequality within relationships, and the tendency of some authors in both traditions to include caring values in their analyses,

³¹ Susan Sherwin, “Ethics, “Feminine” Ethics, and Feminist Ethics,” in *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992), 42.

³² *Ibid.*, 49.

³³ Reich, “Contemporary Ethics of Care,” 338.

³⁴ Susan Sherwin, “Feminist and Medical Ethics: Two Different Approaches to Contextual Ethics,” *Hypatia* 4, no. 2 (1989): 62, accessed June 16, 2015, <http://www.jstor.org/stable/3809806>.

it might appear that medical ethics is already well on its way to being feminist. Medical ethics, however, does not display any commitment to ending oppression; thus most of the writings of contemporary medical ethics must be judged as lacking from the perspective of feminist ethics.³⁵

As one of the greatest criticisms of bioethics (for feminists) as well as the medical profession, Sherwin's perspective confronts the problems within our health care system that are perpetuating oppression or are in some sense not adequately attending to the needs of oppressed individuals (including women, racial minorities, and individuals of a lowered socio-economic status). I include this passage because it both helps to clarify the feminist-feminine distinction and acknowledges that caring values are largely lacking in medical ethics. Most significantly, her criticism points to the inequalities within relationships, which is a major issue we need to confront while evaluating the caring and justice perspectives. I intend to address the problem of inequality between the two orientations later. At least for now in regard to feminist bioethics, one interesting question is does the physician-patient relationship oppress women as women? Does it do so necessarily? Is it inherently oppressive or can it be overcome on a case-by-case basis? These are important and relevant questions, however I do not have the time to fully attend to them here. Uncovering and relieving the oppression of women, though an important issue that regularly demands our attention, is not the direct issue I am primarily concerned with in this work. Nevertheless, recognizing inequality and oppression is essential to evaluating the value of both the caring and justice orientations. This process of identifying oppression and inequality, particularly with women, enables us to critique the justice perspective more effectively and assess how it has often neglected and even concealed real inequality.

³⁵ Susan Sherwin, "Toward a Feminist Ethics of Health Care," in *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992), 83-84.

In “Feminist Directions in Medical Ethics,” Virginia Warren examines three feminist themes for conducting academic medical ethics and leading discussions in moral philosophy. The first theme she cites is diversity. Feminists know that the “one size fits all” approach generally fails when it comes to any ethical theory, and for Warren, “we need to do a lot more listening” in medical ethics.³⁶ This approach enables those caring to recognize and attune to the suffering of those being cared for. The second theme is relationships. For Warren, we need to address the entire personality of the moral decision maker and aim to resolve ambivalent attitudes to positions we deem morally correct.³⁷ Additionally relevant for this second theme is how “winning may take precedence over truth” in our moral deliberations.³⁸ The challenge of competing moral theories or principles may often create competitive stages of moral discourse in which the winning argument is sought prior to an understanding of the realities of particular situations. This brings us to the third theme, that theory should be constructed from one’s life experience and “that life precedes theory.”³⁹ An ethic that takes human experience as morally significant conditions us to recognize suffering, develop compassion, and seriously consider the particular experiences of individuals. Warren’s insights support this discussion, especially the notion that the exclusive support of one moral theory is fallacious and inadequate to address caring and responsiveness to others. To be clear, I am not arguing that the justice perspective should be disposed of. Indeed, the justice perspective, if properly incorporated into a caring ethic, need not be entirely inconsistent with the caring orientation and may be an invaluable

³⁶ Virginia L. Warren, “Feminist Directions in Medical Ethics,” in *Feminist Perspectives in Medical Ethics*, ed. Helen Bequaert Holmes and Laura M. Purdy (Bloomington and Indianapolis: Indiana University Press, 1992), 40.

³⁷ *Ibid.*, 42.

³⁸ *Ibid.*, 41.

³⁹ *Ibid.*, 42.

addition to caring analysis in biomedical ethics. In sections three and four, I would like to investigate the core tensions between the care and justice orientations as understood through the physician-patient relationship and conclude with potential areas of convergence between the two perspectives.

3. THE IMPARTIALIST PARADIGM: IMPLICATIONS FOR MEDICAL ETHICAL THEORY

Moral deliberations in ethics have been predominantly guided by impartial theories in the forms of principles, moral virtues, and social norms. Principlist W.D. Ross offers the most comprehensive set of principles in his seven prima facie duties, which concern future-looking duties, duties based on past obligations, and ongoing duties.^{40, 41} Principlism functions by outlining a set of moral principles that act as the beginning point for moral deliberation. Tom Beauchamp and James Childress assert that principlism originates from the overall norms assumed from the common morality. However, they carefully note that no single basic principle should be accorded priority over any other basic principle.⁴² Their four-principled approach is contextualized within medical situations as follows:

1. Respect for autonomy: a norm of respecting and supporting autonomous decisions
2. Nonmaleficence: a norm of avoiding the causation of harm
3. Beneficence: relieving and preventing harm and providing benefit
4. Justice: fairly distributing benefits, risks, and costs.⁴³

In this paper, principlism is understood as distinct from deontology and duty-based ethical theories insofar as a principled approach to ethics does not always imply appeals to duty.

⁴⁰ Judith A. Boss, "Moral Theory," in *Analyzing Moral Issues*, 6th ed. (New York: McGraw-Hill, 2013), 30.

⁴¹ For the purposes of this paper, I focus on the interpretation of principlism by Tom Beauchamp and James Childress. W.D. Ross provides a more comprehensive account of prima facie duties and valuable insights into how we deliberate on issues concerning justice. Importantly, Ross claims that moral duties cannot be absolute, since there are instances where they conflict (i.e. moral duty of nonmaleficence may conflict with the moral duty to keep a promise.) This goes against the Kantian position that there will never be tension between moral duties, since morality is based on reason. For more on this issue, see Boss 28-31.

⁴² Beauchamp and Childress, *Principles of Biomedical Ethics*, ix.

⁴³ *Ibid.*, 13; 25.

Although Beauchamp and Childress claim to support a model termed by John Rawls as “reflective equilibrium” or “a way of bringing principles, judgments, and background theories into a state of equilibrium or harmony,” their approach to ethical principles appears to be justice oriented.⁴⁴ These four principles have traditionally dominated discourse in bioethical theory, for they constitute the bedrock paradigm of principle-based ethics, at least in medical ethics. I define them here as they will be utilized and evaluated in reference to the care and justice orientations for the remainder of this work. Specifically, Kantian ethics requires one to deliberate impartially. For Sharpe, “the principles of universalizability, impartiality and autonomy that characterize the Kantian moral viewpoint have been welcomed into liberal theory precisely because they establish the priority of the individual and equal moral status for all.”⁴⁵ Liberal theory has provided us with a constructive framework in which to consider one’s individual moral status as premised on the values of equality and freedom. It is not my aim to undermine liberal theory or principled-based ethics but to challenge our exclusive reliance on it in moral decision-making. In his “Experiential Ethics as a Foundation for Dialogue Between Health Communication and Health-Care Ethics,” Warren Reich outlines three main shortcomings of principle-based ethics. First, an ethic relying solely on universal application of principles can exclude individual moral experience from consideration and thus alienate people from their moral selves, since “an ethic that exclusively promotes the use of universal and impersonal language drives a wedge into the person of the professional whose task requires him or her to communicate on moral matters.”⁴⁶ Secondly for Reich, the excessive abstractness and narrowness of moral concern reveals inherent

⁴⁴ Ibid., 404.

⁴⁵ Sharpe, “Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics,” 299.

⁴⁶ Warren T. Reich, “Experiential Ethics as a Foundation for Dialogue Between Health Communication and Health-Care Ethics,” *Journal of Applied Communication Research* 16, no. 1 (1988): 18.

problems with the (Kantian) duties to those who are not fully autonomous. Reich illustrates this second difficulty by acknowledging that under Kantian ethics, the intellectually disabled do not qualify for the Kantian definition of persons, since they cannot be said to be fully autonomous.^{47, 48} Of course today, no one would object to the claim that the intellectually disabled are in fact persons. This example just clarifies the lack of a particularized concern for individuals in an ethic that emphasizes justice and reveals the need for more appropriate methods of caring for those who are not fully autonomous. Lastly, Reich notes that principle-based ethics instills a primary burden on health professionals for communicating.⁴⁹ Arguably, this burden already exists in any ethic of health care. However, a justice-oriented principlism complicates the matter by deemphasizing the values of relationships through which integral communication occurs. These values become inherently distorted by the abstractness of the principle-based approach. Nevertheless, for Reich, the overriding shortcoming of principle-based ethics is that,

A failure to return to experience for moral insights and norms jeopardizes the credibility of ethics. For there are many values and conflicts of values not envisioned by the use of principles; and our actual moral reasoning most often entails values and maxims that are much more experiential than the formal ethical principles we employ in the formulation of ethical policies.⁵⁰

Although Reich is not directly defending the ethics of care here, his emphasis on experiential ethics as the foundation for better communication in health care is consistent with caring values.

⁴⁷ Ibid.

⁴⁸ Some Kantians argue that this is not the case for Kant's theory. Reich's account of Kantian deontology and concept of "person" is sometimes dissonant with other Kantian scholars.

⁴⁹ Reich, "Experiential Ethics as a Foundation for Dialogue Between Health Communication and Health-Care Ethics," 19.

⁵⁰ Ibid., 20.

Reich is rightfully concerned with (experiential) values that are not explicitly derived from principles, such as compassion, kindness, and caring.⁵¹ In accordance with Lindemann's sketch of caring values of engagement with another's will, the caring relationship, and attentiveness to particularities, Reich appears to advocate for a richer ethic that reaches beyond the narrow abstraction of principlism. Despite his critique of the principle-based approach, Reich thinks that principles are both necessary and beneficial to moral discourse. It is not so much a matter of which theory is most correct but that principle-based ethics are both inadequate and incomplete for moral reflection.⁵² Instead of outright rejecting principlism, which would be largely contrary to the development of moral deliberation in health care, Reich contends that "ethics requires a corrective paradigm" in medicine and attending to the suffering of others.⁵³ His point is vital here, for as noted before, I am not trying to completely eliminate the framework of principle-based ethics. Rather, I aim to complement the strength of principles with a "corrective" feature to ethics, not to completely remove principles from moral deliberation. Reich's appeal to a paradigm correction in ethical theory with an expanded focus on experience is both compatible and consistent with the ethics of care. Our moral insights are not purely abstract and are often most fundamentally grounded in our individual experiences. For Reich, the stakes are high as the credibility of ethics teeters on the line of uncertainty. The exposure of these theoretical symptoms reveals the imperative to include experience in our moral deliberations. Having

⁵¹ Reich continues his argument by asking "what is going around me, what is occurring in this moral world" as opposed to focusing exclusively on questions of duty. This is a valuable way to frame our moral considerations under an ethic of care. However, Reich makes the claim that ethics is more of the study of moral behavior than "it is the science of moral principles of duties." I do not completely agree with this. Rather, in my view, it is the reciprocity of principles and moral conduct that demands our attention in all matters of ethics. See Reich "Experiential Ethics as a Foundation for Dialogue Between Health Communication and Health Care Ethics," 20-21.

⁵² *Ibid.*, 19.

⁵³ *Ibid.*, 20.

explicated the principlist paradigm, we are now better prepared to analyze the justice and care orientations and their associations with principle-based ethics.

3.1 The Justice Orientation and Its Challenges

It is important to understand what we mean by “justice,” for there are many different senses in which the term is used. Virginia Sharpe’s article “Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics” examines how the justice orientation has dominated discourse in medical ethics, whereas the care orientation has been both under-valued and not given the serious attention it deserves in patient-provider interactions. Sharpe locates Kohlberg’s claim that “morality is justice” in the deontological or Kantian brand of liberalism (that all individuals equally possess liberties or natural rights and it is by virtue of this fact that individuals bear political rights).⁵⁴ These Kantian roots reinforce Kohlberg’s impartial point of view and emphasis on autonomy. In addition, concern for the moral agent rests on the view that,

In order that he may arrive at universalizable principles of action, the Kantian moral self or person is construed abstractly as making choices in ignorance of his own particular desires, attachments, and attributes... the agent’s moral judgments are based on universally applicable rational considerations, rather than on any subjective concern to achieve a particular end.⁵⁵

This abstract conceptualization of the moral agent allows the moral point of view to be impartial. In another sense, the Kantian moral self may experience some sort of detachment from the particular needs of individual others, since the universalizable principles of action drive the moral agent’s decisions and ethical deliberations. This detachment is problematic for the care

⁵⁴ Sharpe, “Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics,” 297.

⁵⁵ *Ibid.*, 298.

theorist. But before we move to further defend features of the care orientation, we must first review the general tenets of the justice perspective in order to have sufficient understanding of the tension between the two orientations.

Sharpe helpfully reviews the theoretical commitments that undergird the justice orientation. First, since all persons are rights bearers, morally distinctive relationships are marked by reciprocity and equality. Second, justice is blind, for the moral point of view must be one of impartiality.⁵⁶ Third, the commitment to impartiality requires that moral theory and moral practice remain indifferent to particular aims and identities of persons. Fourth, to serve fairness and impartiality, moral judgment must be principle-driven and dispassionate. Fifth, from deontological liberalism, impartiality and universality are best served by a theory with no general view of the good of individuals (i.e. the right comes before the good).⁵⁷ These are all important characteristics of the justice orientation insofar as they theoretically endeavor to defend universal equality and rights among autonomous individuals.

The strengths of these principles of universalizability, impartiality and autonomy, “have been welcomed into liberal theory precisely because they establish the priority of the individual and equal moral status for all.”⁵⁸ Especially under political theory in the United States, emphasis on individual autonomy is essential to how we understand our individual rights or liberties and how we collectively conceptualize ourselves as a nation of autonomous human beings.

Autonomy is the morally relevant characteristic, since the justice view protects individuals from

⁵⁶ However, justice is not necessarily blind. To say that it is would infer that there is no room for convergence between the justice and care perspectives. A better view seeking compatibility with the care perspective would note that the justice perspective frequently emphasizes the abstract. One may consider the justice perspective as historically ignorant of individualized concerns, yet would note that justice views have the potential to account for particularity. In fact, attending to particularity may even enhance or strengthen a justice view.

⁵⁷ Sharpe, “Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics,” 301.

⁵⁸ *Ibid.*, 301.

discrimination on the “basis of arbitrary attributes such as social, economic, or personal status.”⁵⁹ These are all undeniable and really essential strengths that ground our understanding of the moral self. There are many values from the justice perspective that we take seriously by virtue of them belonging to the paradigm as well as considering their use in our present moral deliberations. The central difficulty is that the justice perspective takes the relationship between individual and state as the paradigm moral connection.⁶⁰ This is inconsistent with the caring emphasis on interpersonal relationships and attending to the particular and diverse needs of the other. For Sharpe, “these assumptions disregard many of the features that are distinctive of the healing relationship.”⁶¹ With the caring perspective, people are considered interdependent, not as isolated individuals. In theories of care ethics, morality is viewed “as a matter of reciprocal attachment rather than reciprocal non-interference.”⁶² Annette Baier employs these terms in her essay “The Need for More than Justice,” where she reviews the interconnection of both the chosen and unchosen relationships we enter. Citing Gilligan, Baier notes that “people have real emotional needs to be attached to something, and equality doesn’t give you attachment. Equality fractures society and places on every person the burden of standing on his own two feet.”⁶³ Gilligan unveils this “fracturing” effect in society as the justice orientation takes the assumption of equality for granted. The first break of this fracture likely originates from the detachment one experiences through the privileging of autonomy as a primary principle in ethical theory. Baier

⁵⁹ Ibid., 299.

⁶⁰ Ibid., 298.

⁶¹ Ibid., 301.

⁶² Ibid., 302.

⁶³ Annette Baier, “The Need for More than Justice,” in *Moral Prejudices: Essays on Ethics* (Cambridge, Massachusetts: Harvard University Press, 1994), 23.

and Gilligan are confronting the issue of non-interference in medical situations, which may slide down the slope to neglect. This fracture in society captures the deficiency of the justice orientation and how Gilligan tries to channel the moral maturity of women in a different voice, namely by rejecting the narrow individualism of western liberalism in ethics. For Baier, the problem is that “rights have usually been for the privileged.”⁶⁴ In this claim, Baier is criticizing the limited scope of a principlist approach to ethics. Impartial and universalizable principles are supposed to protect individuals. However, emphasizing the impartial deemphasizes the particularities of the concrete individual. To summarize the challenges of the justice perspective, “Where, the individual abstractly conceived is the moral starting-point for the justice perspective, in the care perspective, relationships are regarded as prior.”⁶⁵ In other words, relationships are accorded a higher moral status than the individual singular, for relationships serve as a medium for understanding the idiosyncrasies of individual persons. Relationships are prior insofar as we understand that our relationality morally precedes our individuality. Human beings do not just exist as isolated individuals. Rather, it is our interrelatedness that binds us to relationships as we grow in our moral decision-making. It is now that I wish to review the care orientation in more depth.

3.2 The Care Orientation in ‘The Voice of Care’

In contradistinction to the justice perspective, Gilligan establishes that the care perspective is outside the realm of the justice theory because it privileges “our moral responsibilities toward those whom we regard not impartially, but partially –as particular

⁶⁴ Ibid., 26.

⁶⁵ Sharpe, “Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics,” 302.

individuals with particular relationships, needs and vulnerabilities relative to us.”⁶⁶ In this way, the component of partiality is a legitimate tenet of caring and is actually necessitated by our movement to care for others. In “The Voice of Care: Implications for Bioethical Education,” Alisa Carse examines the justice and care orientations as analyzed by Carol Gilligan. Carse reviews the major challenges of the justice orientation, particularly the demarcation of impartiality as the moral point of view. The problem for the care theorist is that impartial demands cannot always inform us adequately about how to respond to others. It is not to say that impartial discernment is not sometimes appropriate to our moral deliberations. Instead, it is a claim that the impartial viewpoint does not have special authority in deciding the moral validity of actions and judgments.⁶⁷ For Alisa Carse, the paradigmatic reliance on principlism and the justice orientation, “has had the effect of ascribing a derivative, secondary status to forms of epistemic skill,” which involve particularity.⁶⁸ That is to say that the paradigmatic and exclusive reliance on universalized principles in our moral deliberations reduces the importance of nuance and particularity, which are often of primary moral value in the care perspective.⁶⁹ Again, care theorists do not necessarily have to remove their deliberations from principled analyses. In fact, removing principles from moral deliberations would likely increase the difficulties with responding to others, for the language and terms in which we understand our motivations to act by the virtue of caring would be altogether absent. By focusing exclusively on the application of

⁶⁶ Ibid., 301.

⁶⁷ Alisa L. Carse, “The ‘Voice of Care’: Implications for Bioethical Education,” *Journal of Medicine and Philosophy* 16 (1991): 10.

⁶⁸ Ibid., 10.

⁶⁹ Carse, “Impartial Principle and Moral Context,” 166.

universal principles, impartial justice becomes blind to the contours of suffering and the needs of dependent individuals.

Sharpe gives a helpful summary of Gilligan's moral salencies as interpreted by Alisa Carse. First, one main function of morality is the development of character traits and sense of personal responsibility.⁷⁰ The degree of our responsiveness is thus critical to our care of individual others. Second, the main objective of moral responsiveness is to visualize others as "singular concrete individuals with unique histories and desires."⁷¹ This is how partiality is legitimate under care ethics. Under this view, the one caring has a wider context for understanding the one being cared for as well as responding to the corresponding needs that the one cared for has. Third, the call for a moral response arises as we encounter the needs of others. These encounters are often characterized by inequality and dependency.⁷² In contrast to the emphasis of equality in the liberal view, inequality is a reality that must be recognized and not dismissed as a mere abstract moral view. Inequality, at least among those who are vulnerable or dependent, is a reality that must be confronted with caring values and attentiveness to detail. Without heeding attention to inequality, health care providers will likely inhibit their own capacities for caring. Indeed, the notion of equality is really an ideal and does not correctly account for the experiences of those who suffer from particularized medical conditions and lack access or means to adequate medical attention. Lastly, ethical caring requires the development of emotions that will enable us to discern and respond to the needs of others.^{73, 74} These emotions

⁷⁰ Sharpe, "Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics," 303.

⁷¹ Ibid.

⁷² Ibid., 303.

⁷³ Ibid.

⁷⁴ Carse, "The 'Voice of Care': Implications for Bioethical Education," 11-15.

certainly include a caring attitude, which doubles as the motivation of those doing the caring. We will see later how all of these tenets of caring are significant to patient-provider relationships and vital to their sustainability as genuine interpersonal interactions that aim at healing and caring for the whole person.

Alisa Carse argues that impartialism leaves many moral capacities unaddressed, such as informed consent in the physician-patient relationship. In “The Voice of Care,” Carse provides four main criticisms of impartiality. Her first criticism is that impartiality is the mark of the moral. This critique of impartiality can be best understood as the claim that there is no single or privileged justificational standpoint in morality.⁷⁵ I agree with this claim, for it does not in itself entirely exempt principles from our moral deliberations. Rather, it simply says we cannot exclusively rely on those principles. Carse’s second criticism is how moral judgments are principle-derived. The main problem under this second criticism is locating where principles apply in moral judgments.⁷⁶ Care theory wants to move away from the conception of moral judgment as essentially principle-driven. A theory of moral judgment that is principle-driven cannot, for care ethics, illustrate adequately how to judge the moral *ought*.⁷⁷ Notwithstanding, principles may be “indispensable” for locating the moral stakes of decisions and checking on the welfare of others. Carse’s third feminist criticism of impartiality is the challenge of moral intellectualism for the justice perspective. This challenge is twofold. First, emotions are a vital feature of moral discernment, for we often discern the conditions of others through engagement

⁷⁵ Ibid., 9.

⁷⁶ Ibid., 10.

⁷⁷ Ibid., 12.

with our emotions.⁷⁸ Traditionally, emotions are often viewed as distractions or detractors from impartial moral judgments. For Carse, this is problematic because emotions, when properly cultivated, alert “us to morally salient dimensions of situations.”⁷⁹ These moral salencies may range from perceiving the troubles of a child to ascertaining the complex medical and psychological challenges of an Alzheimer’s patient. The second part to this criticism is that emotions “play an important expressive role in moral response,” for it is not just what we do that is important but how we do it.⁸⁰ This is one characteristic that distinguishes the care orientation from the justice orientation insofar as care brings attention to the moral content of the situation, not merely the abstract framework in which we often (inappropriately) universalize principles for particular aims. To underscore this point, “the emotional quality of our response to another is not just a matter of the motivation out of which we act; it is also a matter of the manner in which we act. This is an important distinction, for the treatment of emotion in ethics is standardly confined to an assessment of the motives of actions.”⁸¹ For the care theorist, confining emotions to an evaluation of our motivations for caring actions is incorrect. These emotions or epistemic skills should be used to develop and sustain caring relationships between those caring and those being cared for.

Carse’s fourth and final criticism of the justice orientation concerns how we model our relationships. The overriding tendency in liberal theory or the justice perspective is to emphasize reciprocity in human relationships.⁸² This tendency has some benefits such as combating

⁷⁸ Ibid., 13.

⁷⁹ Ibid., 14.

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² Ibid., 15.

discrimination and recognizing the mutuality of interdependence between individuals. However, the weight given to these so-called “equals” has led to silence in moral theory concerning particular relationships characterized by material inequality of power, knowledge, and vulnerability.⁸³ This silence is part of the aim of Gilligan and feminists alike to make the voice of care and women heard. In the paradigm of principle-based ethics, “the existence and value of particular relationships and of human relationship more generally are treated as resting in individual choice. Relationships are construed as among the autonomously affirmed goods we are, as individuals, to be at liberty to pursue.”⁸⁴ This further exemplifies the reality of our mutual-interdependence of existence. However, it does not attend to those relationships that are unchosen.

Alisa Carse criticizes the idealism of the impartialist standpoint in morality and concludes that there is no single justificational standpoint in morality. At least for Gilligan’s *Different Voice*, “Its critical lesson is not to denigrate the propositional commitments of the justice orientation but to challenge the privileging its emphases receive in the practice of theorizing. . . . Gilligan does not object to the justice orientation per se, but to our exclusive reliance on it.”⁸⁵ This claim is consistent with the arguments constructed by Carse and Virginia Sharpe and implicitly through Reich. Another important point to reemphasize is that we do not always choose our relationships. For Sharpe, “Since relationships are regarded in the care perspective as prior to individuals, unequal and unchosen (as well as equal and self-assumed) relationships can be accorded moral significance and responsiveness rather than contract [*sic*] becomes the basis

⁸³ Ibid., 16.

⁸⁴ Ibid., 16-17.

⁸⁵ Little, “Care: From Theory to Orientation and Back,” 198; 202.

for moral interaction.”⁸⁶ In section four, I will review how this particular conception of relationships is at odds with our contemporary view of medical relationships, especially regarding physician-patient interactions, where contractual principles of informed consent and respect for autonomy are necessities to delivering care that is both legal and moral.

3.3 Criticisms of the Care Orientation in Biomedical Ethics

I would like to offer a few challenges and critical responses to the care orientation in order to better understand its relationship to the justice orientation. This review of the care orientation will help direct us to methods, which may potentially alleviate the theoretical tensions between the care and justice perspectives. Warren Reich offers a series of objections to the ethics of care, which I find are legitimate but constructive criticisms of the care orientation and move us into a direction of convergence between the care and justice orientations. His first concern is that an ethic of care may actually undermine feminism by disempowering women by emphasizing caring as a virtuous female quality.⁸⁷ Recall the feminist-feminine ethics distinction, where feminism shares the effort to include women’s experiences but extends feminine ethics by combating the institutional oppression of women. *Caring*, through mothering and other paradigmatically feminine roles, does not need to be confined to females. In fact, Nel Noddings claims that, “an ethical orientation that arises in female experience need not be confined to women.”⁸⁸ Reich’s second criticism is that “care” cannot function as a complete end in itself and instead should be balanced with the justice orientation.⁸⁹ I do not interpret this as a stark criticism of the care orientation but rather as an opportunity for convergence between the

⁸⁶ Sharpe, “Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics,” 302.

⁸⁷ Reich, “Contemporary Ethics of Care,” 339.

⁸⁸ *Ibid.*, 340.

⁸⁹ *Ibid.*, 339.

two. It is true that the caring orientation cannot operate singularly and isolated from other ethical perspectives, just as good caring relationships are not sustained remotely and in isolation. Third, Reich offers that caring for others can actually lead to the neglect of the self.⁹⁰ This claim is legitimate and is certainly illustrated by the long and taxing hours health care professionals work to care for their patients. However, this extension of oneself is a hallmark of our human interdependencies and constitutes part of the charge for taking care of vulnerable individuals. Fourth, the concept of care is not helpful at the institutional or social level. Reich contends that the ethics of care cannot be formulated into general rights or principles that are typically used to implement public policies.⁹¹ This is a much broader challenge, for it ingrained in the institutional framework, functions, and expectations of how modern health care works. Present day health care providers are often overworked and flooded with more patients than is sustainable for a genuinely caring medical practice. Additionally, the process of insurance coverage prevents many suffering individuals from receiving the quality of health care that their particular conditions demand. Truly, this is a political challenge and will require more than the efforts of care ethicists to reform these problems. However, at least in the meantime, bioethicists and medical practitioners alike may at least increase their awareness of medical injustices and consider potential steps to remedying them given the current institutional framework of health care.

Another significant criticism of care ethics is that in ethical theory generally and biomedical ethics specifically, relationships are not always positive contributors to a person's identity. In fact, caring in some contexts may be detrimental to the effective care of others. In their *Principles of Biomedical Ethics*, Tom Beauchamp and James Childress note that,

⁹⁰ Ibid.

⁹¹ Ibid.

We can produce rough generalizations about how caring clinicians should respond to patients, but these generalizations cannot provide adequate guidance for all interactions with patients. Each situation calls for a set of responses beyond generalizations, and actions that are caring in one context may be offensive or even harmful in another.⁹²

Noting one of the greatest constraints for the caring model, Beauchamp and Childress highlight a mistake that is easy to make in medicine as well as other fields: thinking that a general good or aim will apply to all individual cases or situations. I find it intriguing, for at least in my reading of this passage, there is a subtle dichotomy between emphasizing individual autonomy in the justice perspective and its inherent neglect of the particular characteristics or dispositions of those autonomous individuals it defends. While the justice or principle-based orientation calls for universalizability of moral concepts, it also defends the individual as the priority object of ethical consideration. Interestingly, the care orientation focalizes on the particular experiences of the same autonomous individuals that the justice perspective is committed to protecting. So in a way, it seems that the care and justice orientations are simply two approaches to the shared goal of attending to the needs and rights of individuals. The essential distinction is that while those assuming the justice orientation privilege the rights and equality of individuals as part of a larger social scheme, the care orientation grants priority to the particular experiences and needs of those individuals. What I am trying to convey is that there are definitely potential points of convergence between the two orientations. I think that perspectives of deontological liberalism, where the right comes before the good, may often be consistent with the ethics of care. Likewise, I think that attending to the particular needs and moral salencies of individuals can and should sometimes be conducted in an “objective” or “impartial” manner in order to maximize the

⁹² Beauchamp and Childress, *Principles of Biomedical Ethics*, 36.

autonomy of the individual. With these claims in mind, I would like to consider how the two orientations could share the role of conducting moral deliberation in medical ethics.

3.4 Justice and Impartiality: Can there be congruence with Care?

In a defense of the care orientation from the justice orientation, one of the most significant questions we can ask is, “What is it that comes into view from the ‘care perspective’ that is not seen from the ‘justice perspective’?”⁹³ Annette Baier poses this question in her essay “The Need for More than Justice,” where she criticizes the predominant focus on obligations rather than virtues in ethics. Her main complaint against Kantian morality is that justice is the first and foremost virtue in society. Baier contends that the ideal of care cannot be fully developed without close cooperation of others, which theories premised on a respect for rights often neglect.⁹⁴ This neglect occurs through the universalization of our principles and justifications of our actions. For Baier, “in concentrating on obligations, rather than virtues, modern moral theorists have chosen to look at the cases where more trust is placed in enforcers of obligations than is placed in ordinary moral agents, the bearers of the obligations.”⁹⁵ In other words, by emphasizing our duties to others over the cultivation of our own virtuous character traits, we arrive at a state of inequality of trust and power between two individuals. Within the patient-provider relationship, this challenge is crystallized as physician duties (such as respect for autonomy and assessing an adequately informed consent) conflict with the practical realities of the patient’s medical condition, which may be at odds with the physician’s duties. In Baier’s view, David Hume, unlike Immanuel Kant, focuses on the development of character traits. Under

⁹³ Baier, “The Need for More than Justice,” 21.

⁹⁴ *Ibid.*, 25.

⁹⁵ Annette Baier, “What do Women Want in a Moral Theory?,” in *Moral Prejudices: Essays on Ethics* (Cambridge, Massachusetts: Harvard University Press, 1994), 13.

Baier's analysis, Hume's moral theory and attention to interpersonal relationships differs from Kant's, for it acknowledges that our relationships are often unchosen and how this unchosen nature is the paradigm of our moral ties, so "one's giving rise to moral obligations [is] more self-evident than obligations to keep contracts."⁹⁶ For Baier, the best moral theory would incorporate men and women by harmonizing justice and care. In her analysis,

The emphasis on care goes with a recognition of the often unchosen nature of responsibilities of those who give care... contract soon ceases to seem the paradigm source of moral obligation once we attend to parental responsibility, and justice as a virtue of social institutions will come to seem at best only first equal with the virtue, whatever its name, that ensure that the members of each new generation are made appropriately welcome and prepared for their adult lives."⁹⁷

In this way, justice is a social value. Yet, it is often a contractual social value that conflicts with certain unchosen features of relationships. Baier's Humean interpretation integrates justice and care in order to adequately attend to moral obligations or responsibilities to others while simultaneously appreciating the individual and particular needs of the other.

For Gilligan, the justice and care orientations are not mutually exclusive nor are they opposites. Rather, "these perspectives denote different ways of organizing the basic elements of moral judgment: self, others, and the relationship between them."⁹⁸ Again, the care-oriented criticism of impartiality is most clearly understood as the "claim that there is no single or

⁹⁶ Annete Baier, "Hume, the Women's Moral Theoris?," in *Moral Prejudices: Essays on Ethics* (Cambridge, Massachusetts: Harvard University Press, 1994), 61.

⁹⁷ Baier, "The Need for More than Justice," 30.

⁹⁸ Carse., "The 'Voice of Care': Implications for Bioethical Education," 6.

privileged justificational standpoint in morality.”⁹⁹ Alisa Carse recognizes an area of convergence between the two orientations in that,

Both deontologists and consequentialists have standardly required that moral prescriptions be justified from an impartial standpoint. But nothing prohibits prescriptions so justified from acknowledging partial duties and special obligations, pertaining, for example, to people in virtue of the roles they inhabit or the specific relationship in which they stand to others.¹⁰⁰

In an article that expands upon “The Voice of Care,” Carse reviews an accommodation strategy that considers the constraint of impartiality as no more than a norm of fairness. Essentially, her accommodation strategy to the care-justice problem simply sets the requirement that similar cases be treated similarly.¹⁰¹ I find this strategy both reasonably consistent with the integration of the care and justice orientations as well as productive in the current demand for equal treatment or insurance coverage in health care. Carse further iterates that, “the ethic of care highlights the moral risk of relying too single-mindedly on abstract judgment –the dangers of obtuseness and incomprehension that render judgment poor and ultimately unhelpful to those whose lives or well-being is [*sic*] at stake.”¹⁰² Importantly, judgment is not limited to the justice perspective and rather can be used in any theoretical orientation within a medical setting. It is likely that exclusive reliance on either perspective would hinder the judgment of health care professionals and limit their capacity to gauge the particular experiences and needs of a patient. To recapture the point I have been defending and to further clarify the theoretical dissonances

⁹⁹ Ibid., 9.

¹⁰⁰ Ibid.

¹⁰¹ Carse, “Impartial Principle and Moral Context,” 155-56.

¹⁰² Ibid., 165.

between both perspectives, “the focus on paradigms of abstraction, generality and uniformity are criticized as exerting normative pressure in the direction of attending to commonality rather than difference.”¹⁰³ So in effect, primary attention to commonality has the tendency to conceal the diverse experiences of individual persons. However, defenders of the care orientation need to evaluate the particular experiences and medical conditions in reference to our shared capacity for suffering. As gleaned from Jeremy Bentham, this is likely one of our most commonly shared traits. In order for care theory and justice theory to converge, both orientations need to consider the particular stakes of individually evaluated situations by attending to the unique and complex medical conditions of distinguished individuals. Additionally, for the two orientations to unify, both need to also consider their decisional consequences for a greater (medical) morality in which caring is just, and justice is caring.

¹⁰³ Ibid., 155; 156.

4. THE INEQUALITIES OF THE HEALING RELATIONSHIP: IS THE ETHICS OF CARE COMPATIBLE WITH PELLEGRINO'S MEDICAL MORALITY?

Technological and epistemological transformations in modern health care require a closer examination of the physician-patient relationship. The importance of this relationship cannot be overstated given the evolving nature of medicine in science, the humanities, and how society receives medical advances. Dr. Edmund Pellegrino devoted his life and research to understanding and improving the quality of this relationship. His groundbreaking “Philosophical Reconstruction of Medical Morality” in *A Philosophical Basis of Medicine Practice: Toward a Philosophy and Ethic of the Healing Professions* revisits the physician-patient relationship and maps out where bioethics has taken us as well as the difficulties in medical ethics we must attend to in the present and future. For Pellegrino, “the relationship between the professional and those he serves is characterized by an inequality in which the professional holds the balance of power”.¹⁰⁴ It is this very power-differential, if we understand knowledge as a sort of power, which is an underlying issue in clinician-patient communication. Additionally for Pellegrino, “the physician has a special moral obligation to assure and facilitate the patient’s moral agency, especially in light of the patient’s special vulnerability.”¹⁰⁵ This vulnerability, I argue, is not merely due to biomedical illness but also concerns an inherent gap in knowledge and understanding between physician and patient. Consequentially, I see that this knowledge-gap goes in both directions: that is, the patient lacks particular biomedical knowledge that they seek for healing, and providers often lack the patient’s socio-cultural knowledge and values. For Pellegrino, this is problematic. The physician and patient are tied to one another in a given

¹⁰⁴ Edmund D. Pellegrino and David C. Thomasma, “A Philosophical Reconstruction of Medical Morality,” In *A Philosophical Basis of Medicine Practice: Toward a Philosophy and Ethic of the Healing Professions* (Oxford, NY: Oxford University Press, 1981), 210.

¹⁰⁵ Pellegrino and Thomasma, 214.

therapeutic relationship. For Pellegrino, “Reducing the inequality in information between patient and physician is essential in obtaining a morally valid consent, which is the vehicle for expression of the patient’s moral agency.”¹⁰⁶ This point is critical, since reducing informational inequality enhances the patient’s ability to express moral agency in terms of understanding his or her particular clinical condition. Defining agency and consent is another difficult task for those investigating the physician-patient relationship. At least for now, moral agency is a concept similar to the principle of respect for autonomy but is distinguished from the mere support of autonomous decisions. According to Beauchamp and Childress, the two conditions for moral agency involve both the individual’s capacity to make moral judgments based on the goodness or badness of a decision and the requirement that this individual has morally judged motives.¹⁰⁷ In “Assessing Pellegrino’s Reconstruction of Medical Morality,” Robert Veatch responds to Pellegrino’s observation of the inequality of information by noting that,

What is often not mentioned by those who propound the inequalities in knowledge in the patient-physician relationship is that there is also a knowledge gap in the other direction... The physician is reduced to the dependent status of one who has a very partial, limited, and distorted view.¹⁰⁸

Veatch’s response, though indirectly, illuminates how a justice-oriented approach to principles ethics may actually limit and distort the views of physicians. In other words, we understand the patient’s perspective as distorted or deficient, for she does not have the same training and expert knowledge of a physician. Conversely, Veatch appeals to the physician’s perspective, which is

¹⁰⁶ Pellegrino and Thomasma, 215.

¹⁰⁷ Beauchamp and Childress, *Principles of Biomedical Ethics*, 72.

¹⁰⁸ Robert M. Veatch, “Assessing Pellegrino’s Reconstruction of Medical Morality.” *American Journal of Bioethics* 6, no. 2 (2006): 74. Accessed June 16, 2015.

often limited by the absence of interpersonal connections with patients and their respective value systems. In my view, part of this “distorted” view of the physician has to do with a lack of attention and concern for the idiosyncrasies of medical relationships.¹⁰⁹ Although medical professionals may strictly adhere their moral deliberations and medical care of patients to universal ethical principles, these principles do not always attend to the particularities of relationships. This is how the physician’s view can often be deficient or limited.¹¹⁰

4.1 The Locus of Medical Morality: Justice and Care

In the section titled “Justice and Care: Implications for Medical Ethical Theory,” Virginia Sharpe cites the locus of medical morality for Tristram Engelhardt, Robert Veatch, and Edmund Pellegrino, emphasizing and conceding the view of Pellegrino that the healing relationship is the appropriate locus of medical morality. However, let us first assess the views of Engelhardt and Veatch, since they are examples of the justice orientation applied in medical ethics. For Engelhardt, the appropriate locus of medical morality is the person. His characteristic qualifications for personhood include rationality, self-consciousness, and moral sense. These characteristics establish the moral boundaries of medical relationships.¹¹¹ Nonetheless, his libertarian framework bears a variety of negative consequences for a medical ethic aiming to harmonize justice and care. First, Engelhardt gives the principle of autonomy absolute priority over the principle of beneficence. This is particularly problematic for Sharpe, since Engelhardt’s

¹⁰⁹ I do not intend to caricature all health care professionals, including physicians, as uncaring or dismissive to the particularities of individual relationships. Medical professionals are often limited by their allotted time to individual patients and clinical resources. Thus lack of caring and concern for individuals is not always a result of medical professionals simply not “caring,” but rather due to the limitations imposed by the bureaucratization of health care.

¹¹⁰ In “The Four Principles and the Doctor-Patient Relationship: The Need for a Better Linkage,” Edmund Pellegrino argues that the four principles, as outlined by Beauchamp and Childress, do not need to be abandoned. Instead, these principles may be refigured and established in the reality of the physician-patient relationship.

¹¹¹ Sharpe, “Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics,” 304.

view holds that only consent can trigger the physician's duty to beneficence. Engelhardt's view "is grounded in the principle of autonomy" and does not account for or explain why a physician should decide to benefit those who have given or are incapable of giving consent.¹¹² In other words, Engelhardt's theory does not technically allow the physician to care for an incompetent patient, since he or she is unable to give a valid consent to medical care. Second, children and infants [as well as the intellectually disabled] do not meet the personhood criteria he lays out. Third, his criteria inadvertently give the fact of physical illness nearly no moral significance. For Engelhardt, the moral agent is defined by rational capabilities. However, those suffering from physical illness often do not have fully functioning rational skills. Sharpe objects to this view by asserting that,

illness matters [under Engelhardt's libertarian theory] not because it makes us anxious, vulnerable and dependent on someone else's help, but because the body is a substrate for rationality...A care ethic, by contrast, will acknowledge the emotional and physical significance of illness to the person whose embodiment and life choices are in jeopardy.¹¹³

That is to say, we often manifest our rationality through the particular responses to our individual embodied experiences. These experiences may involve the morally significant instances of illness, where our mortality is endangered. Sharpe argues that a caring ethic will acknowledge the moral significance of our mortal endangerment by acknowledging and tending to the moral relevance of illness. Lastly and most essential for the care theorist, Engelhardt's personhood criteria make no arrangements for care or empathy in our moral responsiveness to others, since

¹¹² Ibid., 305.

¹¹³ Ibid., 305.

the personhood principles are the only crucial features for moral agency. Under the care orientation, the consequence of not tending to the moral salencies of individuals almost removes the potential for caring responses, attentiveness and empathy. This occurs by making autonomy the primary moral requirement (as opposed to caring values and relationality), which may result in neglect and the reduction of moral checks on non-interference with patients.¹¹⁴

In a similar vein, Robert Veatch locates the locus of medical morality in impartially derived principles. Earlier I argued that the paradigmatic view of a justice-oriented principlism has really neglected important aspects of the caring relationship. Sharpe affirms my claim here as she reviews the challenges of impartiality. For Veatch, impartiality is a cognitive capacity we access via the application of a Rawlsian veil of ignorance. In this way, for Veatch, medicine's moral relevance is a function of impartial principles.¹¹⁵ The propagation of principles happens at two distinct levels in Veatch's theory. At the first level of social contract, "the most basic social principles for human interaction" are generated, and at the second level of contract between society and the medical profession, "role-specific duties unique to health care practitioners" are created through patient-provider interactions.¹¹⁶ These interactions are where we recognize the moral functions of impartial principles. The third contract, for Veatch, occurs between individual practitioners and patients but does not function under impartial constraints and rather involves the acquisition of any "residuum" or consequences to balancing the principles derived from the first two contracts.¹¹⁷ Veatch's theory actually suggests that the interaction between physician and patient is not moral at all but rather lies outside of the moral community, which he argues is

¹¹⁴ Ibid., 305-6.

¹¹⁵ Ibid., 306.

¹¹⁶ Ibid.

¹¹⁷ Ibid.

a community of impartiality.¹¹⁸ As with Engelhardt's theory, Veatch's theory of medical ethics does not acknowledge the skills of care, empathy, and attentiveness that define particular relationships with others. This leads to a second concern in response to Veatch's theory. For Sharpe, Veatch's theory constrains physicians and patients by abstract principles and lacks a method for translating these principles to particular cases.¹¹⁹ Veatch's theory implicitly demoralizes the healing relationship, as the physician-patient relationship is not accorded specific moral status. This view of the justice perspective disagrees with the tenets of caring and like Engelhardt's theory, it jeopardizes the capacity of ethics to attend to the particularized and embodied experiences of individuals.

Sharpe argues that a medical ethic honoring the care perspective would be mindful of the uniqueness of the medical relationship between physician and patient. This view of the unique nature of the clinical relationship originates from Pellegrino and Thomasma's analysis of the healing relationship. Sharpe explicates their views by first noting how the healing relationship is marked by the vulnerability of the ill patient. Pellegrino suitably characterizes this experience of illness as "an ontological assault" of disruption, fear, and uncertainty of the one who is vulnerable.¹²⁰ This vulnerability of the patient establishes what Pellegrino names *the act of profession*, where the act or "declaration" that health care providers make extends invitations for help to the patient.¹²¹ As charged through this "declaration," a dependent relationship is thus formed between the one who is ill and the medical practitioner. What distinguishes this

¹¹⁸ Ibid.

¹¹⁹ Ibid., 307.

¹²⁰ Ibid., 308.

¹²¹ Ibid.

relationship of dependency is the fundamental feature of inequality, for the physician holds the knowledge and skills that the patient is without. Thus a contractual model that assumes equality of participants in a relationship is essentially incompatible and inconsistent with the healing relationship.¹²² Given the inequality characterizing the relationship, the physician makes an implicit pledge to not exploit the vulnerable individual. This pledge restructures our notion of respect for patient autonomy by understanding that the willingness to become a patient expresses the awareness that autonomy becomes more limited within the context of illness. Therefore, it is only through the enhancement of the patient's "diminished autonomy" that the physician can truly attend to the patient's needs. In this way, autonomy is not considered a principle but rather a critical feature of working for the good of the patient.¹²³

Pellegrino's second notion of the healing relationship concerns *the act of medicine*, which embodies the moral and technical particularization of medical care, for it acts as "the vehicle of authenticity and the bridge which joins the need of the one seeking help with the promise of the one professing to help."¹²⁴ This act is the telos of the clinical relationship, for its ultimate aim is the good of the patient. Sharpe explicates an important distinction between the right and the good as it applies to particular acts of healing. In her evaluation of Pellegrino's distinction, Sharpe asserts that,

The healing action is right in the sense that it is technically, scientifically and logically sound and in conformity with the patient's medical needs. The healing action is good in the sense that it accords with the goals and values of the patient in the achievement of

¹²² Ibid.

¹²³ Ibid.

¹²⁴ Ibid., 309.

healing or wholeness. A morally sound response will necessarily be attentive to the patient as a particular, concrete individual.¹²⁵

In my view, this distinction reveals a potential convergence of the justice and care orientations, for unlike in the justice orientation where the right precedes the good, both are afforded equal status in the Pellegrino's formulation of the healing relationship for the very fact that they both aim for the telos of the clinical relationship. This telos is a blend of features from both orientations and accords moral significance to both the technical-medical components of the relationship, which the care orientation often places behind caring, as well as the values of patients, which the justice perspective often places behind principles. According to Sharpe, there are two important implications for the healing relationship as we interpret it as unique and the locus of medical morality. First, a theory marking the healing relationship as the locus of medical morality will recognize that moral responsiveness between the physician and patient will necessitate genuine and open dialogue. This dialogue may be fostered by medical ethical theory and bioethical education that focalizes on the expansion of communication skills and empathic inclinations that may empower medical practitioners and their patients to communicate more effectively.¹²⁶ The practical ramifications of assuming this approach in clinical relationships results from the development of interpersonal skills (on the part of the provider), which surpass general 'patient management' to a more genuinely concerned 'patient care'.¹²⁷ Focusing on the structure of the healing relationship carries a second implication for biomedical ethics. This

¹²⁵ Ibid.

¹²⁶ Ibid.

¹²⁷ Ibid.

implication concerns the priority of the duty to beneficence in the healing relationship.¹²⁸ In contrast, Engelhardt's libertarian theory views the physician's duty to beneficence as a secondary function of patient consent, since acknowledging patient autonomy and valid consent to care precedes the duty to beneficence.¹²⁹ Likewise in Veatch's theory, "beneficence is a lower order principle lexically ranked after the non-consequentialist principles."¹³⁰ In a medical relationship oriented to care, beneficence is a primary responsibility. The physician stands in a higher position of power and therefore carries the moral burden of care by committing his or her work to the health of the patient.¹³¹ This burden predicates the healing relationship and distinguishes it as caring-oriented for this reason.

Sharpe reviews other deontological constraints of the justice orientation and defends that, "A care perspective...because it is oriented to human needs rather than to the rights of citizens per se, will readily acknowledge the human commitment to health or healing as the motivating force behind medical activity. As such, a care-oriented medical ethics will be teleological rather than deontological in character."¹³² In this sense, individualized attention to patient needs is prioritized from the more generalized notion of human rights. Certainly, there are instances where this approach could have a negative impact on clinical care, especially in cases where family members or proxy decision-makers are carrying out the wills of a no longer competent

¹²⁸ Obligations and duties often imply justice orientations. However, in "The Four Principles and the Doctor Patient Relationship," Edmund Pellegrino asserts that instead of principles, "we can speak of obligations [as] freely undertaken when we freely offer to help a sick person." In Pellegrino's view, the duty to beneficence does not impose the same deontological constraints that other duty-based principles create, since the duty to beneficence concerns a freely undertaken charge to care for a sick person. See "The Four Principles and the Doctor Patient Relationship," 200-202.

¹²⁹ Ibid.

¹³⁰ Ibid.

¹³¹ Ibid, 310.

¹³² Ibid.

patient. Nevertheless, the point Sharpe is making simply proposes that the moral force driving medical activity is this attention to the human condition, both in illness and value-based ideals. What exactly does Sharpe mean that a care-oriented care ethic would be teleological rather than deontological in character? In footnote seventeen, Sharpe clarifies that she does not mean teleological in the utilitarian sense of emphasizing the mere consequences of medical actions on patients, physicians, etc. Rather, Sharpe invokes teleology in the sense of Aristotelian virtue ethics, meaning the achievement of human flourishing as an intrinsic good.¹³³ This view allows for the care of the whole person to become a medical reality, manifested in the dispositional traits of the physician as these traits are applied to the individualized concerns of the patient. Justice-oriented theory in medical ethics limits the trust between physician and patient as the contractual model of rights and equality establishes confined limits of trust in clinical interactions. Sharpe maintains that the physician-patient relationship is characterized by a fundamental inequality, so in a care-oriented model like Pellegrino's and Thomasma's, the contractual view is replaced by a model of "fiduciary beneficence," or beneficence reinforced by the investment of trust in the physician.¹³⁴

4.2 Evaluating Sharpe's Interpretation of the Care Orientation

After weighing in on the two orientations, Sharpe concludes that, the care perspective insists that moral requirements frequently emerge within a relationship precisely because a vulnerable member of the relationship is not in a position to spell out his or her needs. For this reason, a morality of care, unlike a justice-oriented

¹³³ Ibid, 310; 315.

¹³⁴ Ibid, 311.

morality, does not depend on the pretense of contractual equilibrium as the basis for moral action.¹³⁵

The healing relationship features the fundamental characteristics of inequality, dependency, and vulnerability. When interpreted as a class of virtue ethics, the care orientation in medical ethics emphasizes the significance of the particular conditions and values of patients and the respective dispositions of the practitioners who respond to those patient's needs. The basis for ethical action in medical settings is not premised on the "contractual equilibrium" based on rights and duties to maintain patient autonomy. Rather, ethical action is provoked by the duty of attention to the individualized concerns of others and ameliorating conditions of suffering. A potential criticism of the healing relationship, if we assume it is premised on the care-orientation, is that health care providers do in fact enter a sort of contract when they commit themselves to the good of the patient and duty of beneficence. So, in medical relationships, even if caring is prioritized over principles of justice, clinical interactions still involve some sort of contract where the physician assumes some dutiful role. The care theorist could likely respond that although there may be a sort of contract of the principled duty of beneficence, if it even really exists, it would involve the content of principles and not just their mere application. Alisa Carse develops this insight in her defense of an accommodationist strategy between the justice and care orientations. For Carse, sensitivity to the particulars of context is not just necessary to apply principles in a caring manner but it implies the practical relevance of the content of the principles themselves. In Carse's words, "many of the discretionary judgments about which features of a situation at hand are morally salient and what their practical significance is, are to be reflected in the complex

¹³⁵ Ibid, 312.

formulation of the principle itself.”¹³⁶ What this means is that the principles can and should apply to medical interactions. However, principles are not to be employed in a mechanistic or universal manner but rather are to be manifested through the particular characteristics of a given situation in response to the moral salencies of an individual’s needs. For example, one would evaluate the autonomy of a patient by both appealing to the principled interpretation as well as how this would apply to a patient’s decision-making capacities relative to his or her medical condition. In this way, contextualizing the justice-oriented application of principles is compatible with the care orientation and marks a nexus between the two perspectives. Sharpe does not explicitly reference Carse’s accommodationist strategy, yet these views do not appear to be inconsistent with the tenets of the healing relationship. On the contrary, it appears that by attending to the contextualized content of impartial principles, we may improve our understanding of the patient’s needs and values while implicitly enriching our comprehension of the employed principles. Sharpe summarizes a major criticism of the justice perspective in her assertion that the “narrow construal of the self is also the source of several blindspots in moral theories that are based on the liberal paradigm.”¹³⁷ These theoretical dissonances are practically significant to the healing relationship and are critically relevant to how we can appropriately apply principles that acknowledge the legitimate ethical truth of partiality. Impartial demands ignore the caring qualities of engagement with another’s will and attention to particularities by placing the right before the good. In the healing relationship, the right action of responding to the duty of beneficence is a shared priority of attending to the good of the patient. Through an appropriate application of principles that legitimize the reality of partiality, the gap between the justice and care orientations may bridge, creating a richer ethic that accounts for the embodied

¹³⁶ Carse, “Impartial Principle and Moral Context,” 158.

¹³⁷ Sharpe, “Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics,” 299.

concerns of concrete individuals as well as how their concerns compose a greater ethical fabric of human experience in medicine.

5. A MORE AUTHENTIC MEDICAL MORALITY: THE IMPORTANCE OF HUMAN NEED AND RESPONSIVENESS TO OTHERS

5.1 Caring in Theory and Practice

The preceding sections have aimed to evaluate the challenges between the care and justice orientations and establish where the two may intersect or even blend into a richer medical ethic. Contemporary difficulties in health care concerning resource distribution, insurance coverage, and the amount of time a provider actually has to spend with individual patients are weighty problems that the bioethical theorists cannot confront alone. Analysis and concern for ethics in academics must translate into applied resolutions to the difficulties that permeate the institution of health care. Warren Reich contends that, “a principle-based ethic creates acute problems for forging a link between health-care ethics and health communication; but if the starting paradigm for ethics is experiential, one perceives in that approach a potential for rich exchange and collaboration between ethical and communication theories.”¹³⁸ I do not mean to make the naïve claim that these challenges in health care will be automatically resolved by merely focusing on the experiences of every patient. Truly, so long as there is illness and suffering, we will continue to make valiant attempts to understand the various traits that distinguish our human experience from other beings. However, attention to experience will likely increase awareness of the reality of our human interdependence and the dependence of particular others who suffer from specific medical circumstances. Despite their earlier criticisms of the care orientation, even Beauchamp and Childress assert that the virtues of caring have the potential to “liberate health professionals from narrow conceptions of role responsibilities.”¹³⁹ By expanding

¹³⁸ Reich, “Experiential Ethics as a Foundation for Dialogue Between Health Communication and Health-Care Ethics,” 27.

¹³⁹ Beauchamp and Childress, *Principles of Biomedical Ethics*, 37.

their scope of responsibility and position in a patient-provider context, health care workers can aim to incorporate caring values and emphasis on our interrelatedness to provide better care.

Conversely,

It is not that patients will always be correct in their assessment of what is in their interests. But if they are educated with the assistance of physicians and others and become comfortable telling physicians what their interests are, the patients themselves eventually will be the most reliable sources physicians have of knowing their patients' interests.¹⁴⁰

In this sense, Veatch's characterization of physician-patient communication appeals to the patient directly for knowing an individual patient's goals, interests, and value systems.

Although his view still contends that the clinical relationship is not designated as a moral one, Veatch recognizes that the relationship between knowledge and caring is a significant one. The healing relationship, as it is characterized by the fundamental inequality between physician expertise and patient lack of medical expertise, is an inherently moral relationship. Knowledge does not necessarily lead to caring but widens the potential for it while caring does entail knowledge.¹⁴¹ When we care about another individual, we open the possibility that we will learn something about them with the aim of fostering caring values within a relationship. To whatever degree of analysis, caring values and practices are essential components to empathic relationships, especially within a clinical setting.

¹⁴⁰ Robert Veatch, "Why Physicians Cannot Know What Will Benefit Patients," 41.

¹⁴¹ Maurice Hamington, "Care Ethics and Corporeal Inquiry in Patient Relations." *International Journal of Feminist Approaches to Bioethics* 5, no. 1 (2012): 52-69. Accessed June 23, 2015. JSTOR. 56.

In sum, the caring orientation may converge with the justice orientation at the nexus of just caring and caring justice. Care reasoning is concrete and contextual rather than abstract, yet this claim does not need to entirely reverse the value or force of principle-based ethics.¹⁴² The difficult task is finding where exactly these two perspectives converge in clinical settings and how their convergence contributes to medical and social progress. For Warren Reich, “The moral force of principles relies on the prior reality of care.”¹⁴³ In this sense, the act of caring shares the aims of principle-based ethics that attend to the moral salencies and values of individuals that are manifested in particular medical conditions. Reich intuits one of these potential convergences of the two orientations in our shared capacity for suffering in that “the key to the various constructive consequences of suffering is found not just in the development of one’s own story, but in discovering, integrating, and identifying with an interpretation of one’s suffering.”¹⁴⁴ This process of identification signifies our interdependence and necessitates the effort to attend to the dependent states of others. By identifying with the suffering of another, one has the capacity to enhance the moral agency of the one who is suffering. In review of the application of biomedical ethics to the institution of health care, “[a] principal aim of a medical ethics informed by an ethic of care would need to be to address how our institutions and practices of health care can further empower patients and in general encourage more active participation on the part of the non-experts in their own health care.”¹⁴⁵ Likewise, a medical ethic that takes the justice-orientation into account would helpfully propose solutions to the institutional challenges in health care.

¹⁴² Carse, “The ‘Voice of Care’: Implications for Bioethical Education,” 17.

¹⁴³ Warren Reich, “The Care-Based Ethic of Nazi Medicine and the Moral Importance of What We Care About,” *The American Journal of Bioethics* 1, no. 1 (Winter 2001): 71.

¹⁴⁴ Warren Thomas Reich, “Speaking of Suffering: A Moral Account of Compassion,” *Soundings: An Interdisciplinary Journal* 72, no. 1 (April 1, 1989): 92.

¹⁴⁵ Carse, “The ‘Voice of Care’: Implications for Bioethical Education,” 24.

Through a linkage of the justice and care orientations, we may further empower patients to make informed medical decisions consistent with their life-views, values, and medical experiences.

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