Feminist ethic of care

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Feminist Ethic of Care: A Third Alternative Approach

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A man with Alzheimer's who wanders around, a caregiver who disconnects the alarm, a daughter acting on het own, and a doctor who is not consulted set the stage for a feminist reflection on capacity/competence assessment. Feminist theory attempts to account for gender inequality in the political and in the epistemological realm. One of its tasks is to unravel the settings in which actual practices, i.c. capacity/competence assessment take place and offer an alternative. In this article the focus will be on a feminist ethics of care in which relationality, care, vulnerability, and responsibility are privileged concepts and attitudes. The emphasis on these notions leads to a specific view of autonomy that has consequences for both carereceivers (patients, clients) and caregivers (professional and not professional). These concepts constitute a default setting that shapes the context for capacity/competence assessment. Whereas this notion is meant to distinguish between those who need to be taken care of and those who do not, reflection on what it means to say 'those who need to be taken care of' is also required. The feminist analysis presented here emphasizes the necessity of the contextualization of assessment of competence. It sketches the multifold and complex grid that comprehends capacity assessment.

KEY WORDS: feminist; care ethics; responsibility; competence assessment.

INTRODUCTION

The presentation of Case A. suggests that different individuals participate in the story of the 87-year-old man. It is not clear what their positions are. All players, 'the' daughter, 'the' old man, 'the' doctor, 'the' nurse are anonymous and no relation of equality or inequality, authority or domination is articulated. The

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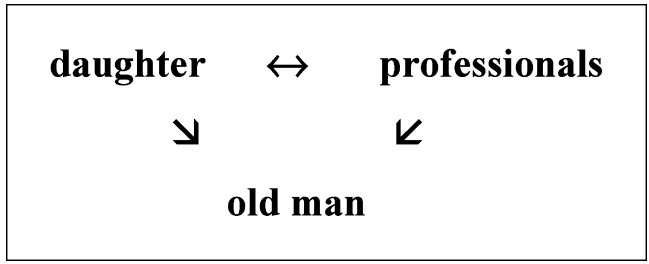


Fig. 1. Simple triangle.

scene evokes a triangle in which the old man is the object of decisions made by others: his daughter or the professionals. These parties are portrayed as antagonistic characters. Their caring activities have no context. The male caregiver who is frequently disturbed by ringing alarm bells seems careless, but maybe his action is set in a context of an understaffed unit where alarm bells have been a means of downsizing staff.

All characters are set in an empty stage in which the daughter and the professionals are acting independently and are detached from any context. They can be pictured in a clean chart (Fig. 1).

All decisions are made without input from the old man. His position is that of *the one who needs to be taken care of*. This presentation is inspired by a particular notion of autonomy in which self-determination is dominant. It is the common conceptual denominator of different contemporary ideas of autonomy (an individual right, a negative liberty, capacity for rational self-legislation). Free and individual choice derives from this basic notion. When a person is unable to excercise this self-determination, others take over. This explains the arrows in the chart, pointing from the daughter towards the old man and from the professionals towards the old man. The old man's competence is questioned because he does not comply with what his carers think he ought to do. The daughter and the professionals have a double sided arrow as they are participating in some kind of conversation with each other in which both parties do not question each others mental capacity.

FEMINIST ETHICS

What is the contribution of a feminist analysis to this case? In order to answer this question, we need to make a sketch of what feminist ethics is about. Many discussions about feminism, c.q. feminist ethics circle around the question how to define it. Authors quickly point out that there is no such thing as 'the feminist standpoint'. Several approaches are outlined and historical overviews show the diversity in time and scope (Warner, 2000). Susan Sherwin has drawn attention to

some core notions that transcend the internal debates: "a recognition that women are in subordinate position in society, that oppression is a form of injustice and hence is intolerable, that there are further forms of oppression in addition to gender oppression (and that there are women victimized by each of these forms of oppression), that it is possible to change society in ways that could eliminate oppression, and that it is a goal of feminism to pursue the changes necessary to accomplish this.' (Sherwin, 1992:29 note 6) Commentators acknowledge that not all those who call themselves feminist will comply with this description. The notion of 'woman' for example will be contested by post-modernists. However, as Donchin and Purdy acutely observe, there are practical, political and philosophical reasons for accepting core feminism. (Donchin, 1999) In identifying what feminism is about, it might lose some of the 'dirty' connotations, e.g. man hating, bra burning, it has received over the last decades. Furthermore, it helps bridging the gap towards other justice movements. Finally, naming core feminism clarifies what feminist theorizing in its attempt at reconstructing theory and practice is about.

Feminist ethics is part of a larger project of feminist theory that 'attempts to account for gender inequality in the socially constructed relationship between power—the political—on the one hand and the knowledge of truth and reality—the epistemological—on the other' (MacKinnon, 1987:147). It deals with theory because fundamental concepts have been shaped in subtle ways by gender understandings and as such frame the way in which perception, conceptualization, and valuation take place (Little, 1999).

In this article, I will focus on an ethic of care as a particular form of feminist ethics (Tronto, 1993; Feder Kittay, 1999; Urban Walker, 1998). I will show how this approach identifies relationality, care, vulnerability, and responsibility as privileged concepts and attitudes. The emphasis on these notions leads to a specific view of autonomy that has consequences for both carereceivers (patients, clients) and caregivers (professional and not professional). These concepts constitute a default setting that shapes the context for capacity/competence assessment. Whereas this notion is meant to distinguish between those who need to be taken care of and those who do not (Silberfeld, 1999), reflection on what it means to say "*those who need to be taken care of*" is required. Ethics of care is "an ethical orientation highlighting concrete and nuanced perception and understanding—including an attunement to the reality of other people and to the actual relational contexts we find ourselves in. (. . .) (Care ethics) asserts the importance of an active concern for the good of others and of community with them, of a capacity for sympathetic and imaginative projection into the position of others, and of situation-attuned responses to others' needs." (Carse, 1995:10) Care ethics turns the attention to the interdependency and vulnerability of human existence. Central idea is the relational self who is connected with others. Care ethics takes the central activity of caring seriously. It is a feminist ethics because it 'refuses to permit a value like caring to "trap" women by requiring them, but not men, to tend others' (Tong, 1999:34).

FROM THE PERSPECTIVE OF AN ETHICS OF CARE

Caring is by its very nature a challenge to the notion that individuals are entirely autonomous and self-supporting. A general definition of care is suggested by Tronto and Berenice Fisher: 'On the most general level, we suggest that caring be viewed as a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web' (Tronto, 1993:103). Caring is an ongoing practice and disposition which is largely defined culturally and will vary among different cultures. The definition seems all-encompassing. However, not all human activity is caring: it only deserves that title when it is aimed at maintaining, continuing, or repairing the world. It is an activity starting from the concerns and needs of the other which is the basis for action. Care involves some form of ongoing connection. 'But one reason to presume that we are all independent and autonomous is to avoid the difficult questions that arise when we recognize that not al humans are equal. Inequality gives rise to unequal relationships of authority, and to domination and subordination. No society exists without such relationships, but neither can democratic order thrive when such inequalities exist' (Tronto, 1993:135). This is a challenge a feminist ethic of care wants to address.

A well-accomplished act of care is described by the four phases of care: (1) caring about; (2) taking care of; (3) care-giving; (4) care-receiving. Caring about refers to the recognition that care is necessary; taking care of is about assuming some responsibility for the identified need and determining how to respond to it; care-giving describes the direct meeting of needs for care; and care-receiving invokes the experiences connected with receiving care. This process corresponds with specific moral skills and attitudes. Caring about presumes an attitude of attentiveness. Attentive presence prevents caregivers from buying into what is so-called self-evident. Acts once done tend to sneak into caring activities and become habits, thereby loosing sight of the real needs of the carereceiver. A man with dementia is labeled a run-away while his real needs might be physical activity. He has been married to his wife for ages but nobody seems to wonder whether she might be able to verbalize his real needs. Attentiveness implies breaking through one's own habits and presuppositions and mapping the real desiderata of the carereceiver.

Taking care of is connected with taking and charting responsibility. It is the result of collective activities of different caregivers. They take the burden of care on their shoulders and act accordingly. Cooperation between different fields of responsibilities remains a difficult field. Power relations between for instance nurses and doctors may hinder good care. The doctor in the case is not amused when the daughter 'takes care' of her father without consulting him. Mapping responsibilities can be strenuous as responsibility is embedded in a set of implicit cultural practices. One is not aware of tacit expectations but acts according to them.

The third phase in the caring process connects to the skill of competence: intending to provide care, even accepting responsibility for it, but then failing to provide good care, means that in the end the need for care is not met. Sometimes care will be inadequate because the resources available to provide for care are inadequate. Showing care implies that the work must be done competently. Caregivers, for example lacking time to answer all alarm bells, cannot do their work competently.

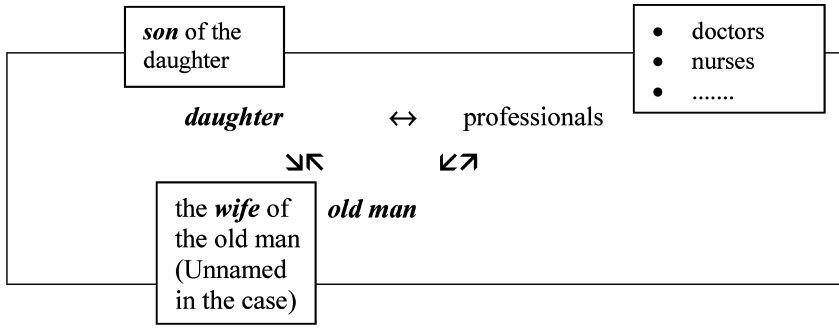
Care-receiving connects with the skill of responsiveness. This involves the reactions to the care that is being offered. How well is the one needing care responding? To be in a condition in which one needs care implies being in a position of some vulnerability. Being attentive to the responsiveness of the carereceiver demands being concerned with conditions of vulnerability and inequality. Analysis of the unequal distribution of power is a necessary element of a caring attitude.

ATTENTIVENESS

This general description of care prepares some of the questions that must be addressed in the case of the 87-year-old man. At first glance (see Fig. 1), the old man, who remains nameless in the description, is surrounded by people and structures that answer his needs: his daughter, the municipal home and its personnel, and the geriatric clinic. I will focus mainly on attentiveness as a necessary skill for attaining an adequate description of the situation. "The insistence on acute and loving perception as a central moral virtue highlights the need for seeing more carefully what is and imagining more responsibly and creatively what might be important for our lives as a community as well as our lives as individuals." (Lindemann Nelson and Lindemann Nelson, 1999:290). Assessment of capacities is always done in a specific situation; therefore description of the situation must be done carefully. The terms, in which the scene is portrayed, prepares the way in which the discussion will develop.

The relational approach favoured by an ethic of care is critical of the dominant notion of autonomy sketched before for it is fundamentally individualistic and rationalistic (Mackenzie and Stoljar, 2000). Terms like freedom and individual choice are multi-interpretable. Is a woman's wish to care for her dementing father her free and individual choice, or is it required by her culture, her surroundings, or her religion? It seems that neither daughter nor father can be seen as isolated from each other nor from the culture they are part of. Attention for the family as a legitimate locus of the individual, in contrast with the view of the family as hindrance to professionals, is an important shift from general perceptions (Lindemann Nelson and Lindemann Nelson, 1995).

The image of an autonomous person reflecting, in splendid isolation, upon the kind of life she wants to lead and the actions she wants to perform whenever she is confronted with other human beings, deciding about the course of action she



In italics: family relations.

Fig. 2. Social relation.

will follow and adhering to the idea that she is master (sic) over herself clearly is a caricature. Some theories about autonomy—and even more so the watered down versions in actual practices—tend to accept the image of the solitary individual who pursues an independent life course. Linda Barclay for instance warns us for a purely procedural notion of autonomy that says it 'consist of a capacity, or the exercise of certain competencies, that enables one to reflect on one's aims, aspirations, and choose one's ends and purposes through such a reflective process' (Barclay, 2000:53).

The autonomous person envisaged in this procedural notion transcends all embeddedness in a specific community or the indebtedness to the social relations that constitute who one is. The individual is presented as a closed box with deliberative capacities. This procedural notion of autonomy denies the social influences on the self. It neglects the effects of others and social structures and systems on who we are (Fig. 2).

"Who we are—what we are like and how we think and act—is significantly influenced by social systems of domination and subordination." (Tietjens Meyers, 2000:153). How a carereceiver will act and think is influenced by his position, his personal life history and how that is guided and directed by the social circumstances in which he lives. The setting in which he receives care will be one of the factors that decides on his autonomy. "Autonomy works in situ, and autonomous individuals must work with whatever material is at hand" (Tietjens Meyers, 2000: 159) (Fig. 3).

Autonomy competency is not something we own, but something we develop, over and over again, in dialogue with others. It is a continuing process in which new situations force people to review what they value and how they want to lead their lives. People reach autonomy in juggling around the material that is handed over to them in specific situations. Most people have some idea about the direction of their lives and usually they do not take steps that diverge tremendously from the direction their lives took before. Most people have been—unconsciously—trained

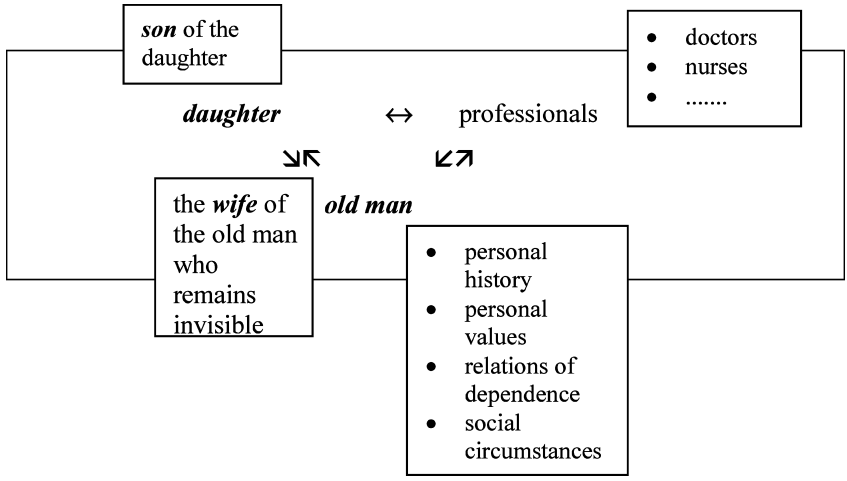


Fig. 3. Autonomy in situ.

in developing their own identity and autonomy in relation to others. This implies that for instance in the setting of health care, patients, clients use the caregiver as a mirror in order to check whether the direction they want to go into is not deviant from whom they want to be.

Donchin characterizes autonomy as relational with reciprocity and collaborativeness as its main features (Donchin, 2000:239). Becoming autonomous is a delicate play between interdependent subjects who are involved in lives that sometimes meet and influence each other. "Our autonomy competency is a debt we owe to others" (Barclay, 2000:58). This implies that those others play an important role in enabling people to become autonomous, a role that can be characterized as collaborative. They will have to act accordingly.

The feminist approach as presented here favours a shift in perspective. The main question is not: how competent or autonomous is this person but how can we enable this woman or man in attaining autonomy and consequently how can we advance her competency in excercising autonomy? A switch is made from the so-called incompetent carereceiver to the caregiver who is one of the actors in supporting, promoting, and fostering the carereceiver. As a consequence, assessment of competence will not only be directed at this particular persons whose competence is in doubt, it will also focus on what means are being used in order to enhance someones competence. Competence assessment is being contextualized in that the context can diminish ones abilities to excercise ones competence. "The capacity to make an acceptable choice with respect to a specific decision" (Weisstub, 1990) is not only an ability of one person, it is an ability enhanced or reduced by the context in which it is excercised. The idea that "decision-making capacity is now generally defined in terms of functional abilities to understand information relevant to a decision, and to appreciate the consequences of the presenting options" (Silberfeld,

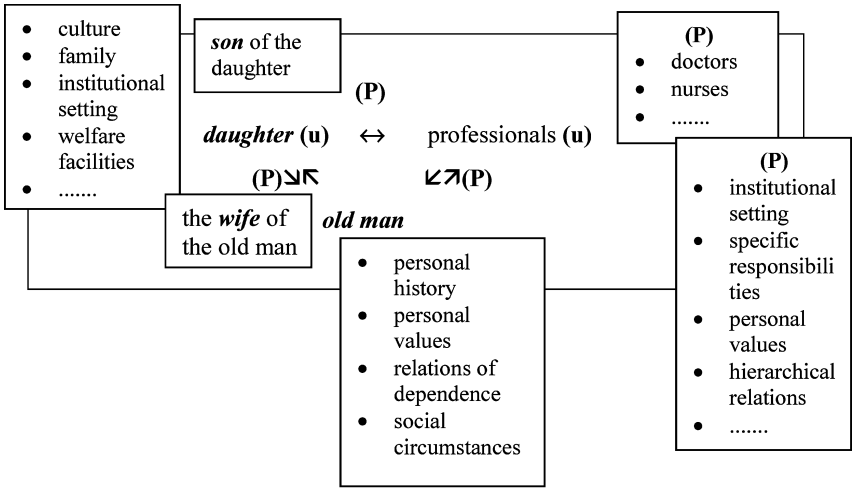
1999:378), is modified by a feminist account. A feminist reading of 'functional abilities' will not only look at the person having these abilities. It challenges the surrounding environment and its actors to explain how it improves or hinders the competence of this particular person.

MORAL UNDERSTANDINGS

The caring process with its connected moral skills as described by Tronto and the notion of relational autonomy following from a feminist analysis of the concept, add up to reflection on the position of the caregivers. A caregiver will need to develop moral skills to avoid the pitfall of undesirable paternalism that can permeate assessment of capacity. It demands a carer who has achieved some lucidity about her own moral understandings of the kind of live she wants to lead, what it means to be continuously involved in the process of acquiring competency skills, and what it means to be a professional who as professional is involved in helping other people labouring on their competency skills. Caregivers who are able to reflect on their own moral understandings know what they are doing when they are assessing someone else.

Transparency is the capacity to reflect on one's own moral understandings so that they do not impede the professional in her work but rather facilitate her in shedding light on the values the client honours. In feminist perspective transparency for instance visualizes gendered arrangements pervading structures of authority and ascription of responsibilities (Urban Walker, 1998). The caregivers' professional identity and activity is formed by the practices she is enrolled in, the institutional setting in which those practices take place, the society that supports those institutions, and other settings she is part of. Professionals ought to be able to map their own responsibilities as they are shaped by these practices and situate their clients and their families in this complex field. The female doctor who is asked about restraining measures for an 87 year-old man reacts differently whether this man is her patient or whether this man is her father. As a doctor she is shaped by the expectations of the group she belongs to: she is supposed to be a professional who has found the delicate balance between emotional involvement and professional distance with her patients. Being a female doctor in the still predominantly male setting of the world of health care, she monitors the aspect of emotional involvement very carefully. As a daughter, the balance is very different. Being a daughter is no natural given; it is a position that is formed through historical and cultural elements, class and colour. In her role as daughter, the environment expects her to be especially emotionally involved. Too much distanced professional involvement would make her seem hard and not caring.

Attentive and responsible care demands a good analysis of the situation at hand. Assessment of capacities is always situated in a complex context that is imbued with relations of vulnerability and dependence. A careful mapping of



(u): (moral) understandings of what it means to be a caring daughter / a good professional determined by context, culture, institutional setting, relations, et caetera

(P): relations of power, equality, inequality

Fig. 4. Competence framework.

responsibilities (Urban Walker, 1998) and power relations will chart the framework in which people's competence is formed (Fig. 4).

CONCLUSION

The ethics of care perspective as briefly introduced here,[3] offers an analysis of the context in which capacity assessment takes place. Whilst figure 1 seemed to offer a straightforward scene, Figure 4 portrays a complex stage that precludes any straightforward model of evaluation of competence. The case presented at first does not seem to ask any questions about whether the old man's mental capacities ought to be assessed or not. He is portrayed as a person who seems totally incompetent and his behaviour, wandering around, 'escapes', not staying in bed, completes this picture. A mapping of the situation in which this happens presents a scenario in which the old man is situated within a specific context and in which he is related to a number of people. They set the stage for any need of an assessment of the competence of the old man. It is possible to imagine a situation where the old man can actively live a life of wandering (after all, he has been physically active for all

[3]The sketch offered here is partial, for more reading, see the references.

of his life) and nightly activity.[4] Whether this is possible is not most prominently a question of how competent he is, but a question about the setting and the limitations this setting brings forth. The above feminist analysis emphasizes the necessity of the contextualization of assessment of competence. It sketches the multifold en complex grid that comprises capacity assessment.

REFERENCES

Barclay, L. (2000) Autonomy and the Social Self. In C. Mackenzie, and N. Stoljar (Eds.), *Relational Autonomy. Feminist Perspectives on Autonomy, Agency, and the Social Self* (pp. 52–71). New York: Oxford University Press.

Beauchamp, T.L., and Childress, J.F. (2001) *Principles of Biomedical Ethics*. New York: Oxford University Press. (Previous Editions: 1979, 1983, 1989, 1994.)

Carse, A.L. (1995) Qualified Particularism and Affiliative Virtue: Emphasis of a Recent Turn in Ethics. *Revista Medica de Chile: organo oficial de la Sociedad Medica de Santiago, Sociedad de Cirurgia de Chile, Sociedad Chilena de Gastro-enterologia, Sociedad, Médica de Antofagasta, Sociedad Chilena de Transfusión y Hematologia* **123**(2), 241–249.

Chambers, T. (1996) From the Ethicist Point of View: The Literary Nature of Ethical Enquiry. *The Hastings Center Report* **26**(1), 25–32.

Dodds, S. (2000) Choice and Control in Feminist Bioethics.' In C. Mackenzie, and N. Stoljar (Eds.) *Relational Autonomy. Feminist Perspectives on Autonomy, Agency, and the Social Self*. New York: Oxford University Press, pp. 213–235.

Donchin, A. (2000) Autonomy and Interdependence. Quandaries in Genetic Decision Making. In C. Mackenzie, and N. Stoljar (Eds.), *Relational Autonomy. Feminist Perspectives on Autonomy, Agency, and the Social Self* (pp. 236–258). New York: Oxford University Press.

Donchin, A., and Purdy, L. (Eds.) (1999) *Embodying Bioethics. Recent Feminist Advances*. New York: Rowman & Littlefield Publishers.

Donchin, A., and Purdy, L. (1999) Introduction. In A. Donchin, and L. Purdy (Eds.), *Embodying Bioethics. Recent Feminist Advances* (pp. 1–13). New York: Rowman & Littlefield Publishers.

Feder, K.E. (1999) *Love's Labor. Essays on Women, Equality, and Dependency*. New York: Routledge.

Lindemann Nelson, H., and Lindemann Nelson, J. (1995) *The Patient in the Family*. London: Routledge.

Lindemann Nelson, H., and Lindemann Nelson, J. (1999) Justice in the Allocation of Health Care Resources: A Feminist Account. In J. Lindemann Nelson and H. Lindemann Nelson (Eds.), *Meaning and Medicine. A Reader in the Philosophy of Health Care* (pp. 289–301). New York: Routledge.

Little, M.O. (1999) Why a Feminist Approach to Bioethics? In J. Lindemann Nelson and H. Lindemann Nelson (Eds.), *Meaning and Medicine. A Reader in the Philosophy of Health Care* (pp. 199–209). New York: Routledge.

Mackenzie, C., and Stoljar, N. (Eds.) (2000) *Relational Autonomy. Feminist Perspectives on Autonomy, Agency, and the Social Self*. New York: Oxford.

MacKinnon, C. (1987) *Feminism Unmodified*. Cambridge: Harvard University Press.

Sherwin, S. (1992) Feminism and Medical Ethics: Two Different Approaches to Contextual Ethics. In H. Bequart Holmes and L. Purdy (Eds.), *Feminist Perspectives in Medical Ethics*. Bloomington: Indiana University Press.

Silberfeld, M., and Checkland, D. (1999) Faulty Judgement, Expert Opinion, and Decision-Making Capacity. *Theoretical Medicine and Bioethics* **20**, 377–393.

Tietjens Meyers, D. (2000) Intersectional Identity and the Authentic Self? Opposites Attract! In C. Mackenzie, and N. Stoljar (Eds.) (2000) *Relational Autonomy. Feminist Perspectives on Autonomy, Agency, and the Social Self* (pp. 151–180). New York: Oxford University Press.

[4]For example, a house in which double day rhythm is possible.

Tong, R. (1999) Just Caring about Maternal-fetal Relations: The Case of Cocaine-using Pregnant Women. In A. Donchin, and L. Purdy (Eds.), *Embodying Bioethics. Recent Feminist Advances* (pp. 33–43). New York: Rowman & Littlefield Publishers.

Tronto, J. (1993) *Moral Boundaries. A Political Argument For an Ethic of Care*. New York: Routledge.

Urban Walker, M. (1998) *Moral Understandings. A Feminist Study in Ethics*. New York: Routledge.

Warner, S. (2000) Feminist Theory, the Women's Liberation Movement and Therapy for Women: Changing our Concerns. *Changes. An International Journal of Psychology and Psychotherapy* **18**(4), 232–243.

Weisstub, D. (1999) *Enquiry on Mental Competency.* Toronto: Queen's Printer of Ontario.