Care and Institutions with Elizabeth Lanphier

Christiane Wisehart, host and producer: I'm Christiane Wisehart, and this is Examining Ethics, brought to you by The Janet Prindle Institute for Ethics at DePauw University.

[music: Blue Dot Sessions, Gin Boheme]

Christiane: When I think of care ethics, intimate friendships or family relationships often come to mind. My guest today, the clinical ethicist and professor of philosophy Elizabeth Lanphier, explains that care is not always intimate or familiar. She argues that if we want care to be fair and just, we need to think about the ethics of care in institutional settings as well as more personal ones.

Elizabeth Lanphier: A lot of people that are cared for in healthcare settings are not intimately cared for. They're not necessarily cherished by the individuals caring for them. They don't have affective relationships between patients and the medical providers that are providing care, and yet this care is provided…I think that we actually have models for ways in which care can and is at times not about affective relationships or intimate kinship relationships and that those provided some real insight into ways in which we could or should be thinking about care differently from this institutional standpoint around how we actually create structures of care that can hopefully more fairly and equitably, and this is where it comes back to justice, make sure people's caring needs are met.

Christiane: Stay tuned for our discussion on today's episode of Examining Ethics.

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[interview begins]

Christiane: Elizabeth Lanphier, welcome to the show. We're here to talk about a piece of yours called "An Institutional Ethic of Care." So just briefly, can you kind of give us an introduction to what you're doing here in this article?

Elizabeth Lanphier: This article really is trying to look at the history of care ethics and care theory that arose really out of some feminist philosophy and this movement around feminist ethics of care in the 1980s and 1990s that tried to think about how care might inform our ethical relationships often using family relationships, mother-child relationships, as these four touchstones of how we might theorize care in different ways in these feminist ways.

And so I'm looking at sort of a trajectory in history in that literature that turns toward maybe more intimate or family relationships as sources of thinking about ethical theory, and I'm trying to explore what it might look like to really think about some of those concepts and theories in what

I'm calling an institutional sense and recognizing the ways in which care shouldn't be or isn't only about these interpersonal relationships that might have been foundational to care ethics in its development, but could, or I argue, should be part of actually thinking about just societies and really obligations that we, as individuals, have to care for others and rights to or benefits of care that people are due really as a matter of not just being in interpersonal relationships but really as a matter of justice, is the way I'm thinking about it.

Christiane: We've talked about care ethics on this show before, but just to give us a little refresher about care ethics, could you sort of briefly tell us what care ethics is and then we can get into the nitty-gritty of your thesis in a minute?

Elizabeth Lanphier: Care ethics is going to be ethical theory that is motivated by ethical relationships in caring relationships of care, recognizing that individuals require care, and individuals both choose and may obligated to provide care, and what those relationships of care, both giving and receiving care, can inform about ethical behavior, ethical values, and really an ethical theory.

And so care theory then kind of comes out of a couple lines of thinking, but one is a feminist ethics that looks at familial relationships, certainly mother-child relationships and the ways in which Virginia Held, for example, talks about the parent-child relationship being sort of a foundational relationship upon which everyone is reliant in order for essentially anything that follows in society to come to fruition. We need those core caring foundational relationships to get to be democratic citizens or people moving through society. And it's looking at kind of chosen and unchosen relationships of care often modeled on but not exclusively mothers and children or parents and children or families to really think about ethical obligations to and of others.

Christiane: You mentioned earlier that you are trying to bring in the idea of a just society into this theory of care ethics. And so…you mention in your piece that there's a kind of tension between care and justice, so could you kind of flesh out that tension for us?

Elizabeth Lanphier: There is this tension internal to care ethics, to some extent, around whether care is prior to justice, justice is prior to care, whether they need to work in tandem. I suggest they work in tandem, right? And so one thought is that for those who maybe are less steeped in history of philosophy or ethical theory, right, we might say that, traditionally, many theories of justice or ethical theories are about thinking about abstract concepts of justice and fairness, how to have a just society in which everyone receives their fair share. And feminist ethics and care ethics in particular responds to that a little bit by saying, well, it's actually really hard to universalize in these ways.

And when we think we're universalizing, we're actually missing out on a whole bunch of specifics that are potentially marginalizing individuals or groups that we've historically overlooked. The fact of marginalization or oppression of specific groups or individuals from our theorizing and from our kind of constructs of a just society by presuming that this sort of

universal standard even exists in the first place. Right? And so I think stepping back a little bit and recognizing that feminist ethics and care ethics are responding to that history, that's really questioning even the possibility of some of these universalizing categories and the ways in which justice is thinking about kind of everyone receiving their fair share in these universal senses, is important to understand why justice and care might be in tension sometimes, right, because I think there's a move in care ethics to say, well let's stop focusing so much on these universal concepts of justice and fairness and focus on these intimate interpersonal relationships of care.

And I think that that has a real importance and function sort of in the history of philosophy and for feminist ethics and does really good work. My argument is to sort of move past that a little bit and say, "Okay, but we can recognize that care and justice might actually go together and don't need to be binary opposites, but they're actually really important to work in tandem," and so recognizing care sort of as a good or a practice that also needs to be or might need to be distributed or redistributed according to some principles of fairness, for example, that justice might help us think about.

Christiane: Could you help us kind of picture this tension with an example, maybe an example that takes place in a kind of care setting, like a hospital or something?

Elizabeth Lanphier: That’s great, because I do work in a healthcare setting, and a lot of this essay is really motivated by healthcare practices and thinking about how healthcare is kind of this instantiation of both justice and care that need to work in tandem, ideally and practically. So the example I run was really thinking about organ transplant. And we kind of think about organ transplant as primarily motivated by principles of fairness: the most fair thing to do is to give an organ, which is a scarce resource, right, there's more people who are on transplant wait lists than there are organs available for transplantation. So giving that organ to the person who is most likely to benefit and sort of shepherd that resource fairly, right? That is the fair allocation.

How we determine who's most likely to shepherd that resource fairly though gets into the weeds a little bit, right? And so we can look at certain medical facts around likelihood of success of transplantation based on other underlying health conditions, whether the organ itself is a good fit for the particular recipient. And so there's all sorts of medical criteria that go into organ transplant. And I should say here that different organs have different criteria. But for many organs, there are also these psychosocial criteria. And the psychosocial criteria involve things like having access to available caregivers to support you after you receive your organ. One of the reasons for that is, arguably, that that's actually going to help the outcomes, right? There's more likelihood of a good transplant outcome and a successful transplant if you have access to people to help support your immediate care needs following transplantation for some number of weeks or months.

But we can see that this criterion that is really designed to be about fairness and making sure that the organ goes to the person who's most likely to benefit, because that's really a concept of fairness, actually really relies on care, right? It really relies on interpersonal care. It really relies on having resources available, whether it's friends or families or kinship relationships, or if you

don't have those, the ability to pay for professional caregivers in order to supply that aspect of the transplant criteria. And so I think that in this way, we can see that there's these kinds of broad principles of justice and fairness in organ transplantation that still fall back on and rely on access to caring resources. And so care becomes somewhat a matter of resource distribution like any other good.

Christiane: The example that you gave in your essay was really compelling to me because you told the story of a man who, let's say, he was abusive to his family and he alienated all of his friends and family and then comes up on the list for an organ transplant, is suitable, is allowed to get the organ transplant, but has no help, has no care afterwards. And so I really like that as an example of where care and justice kind of are in tension with each other. And so that's where I think your theory comes in: an institutional ethic of care. To start fleshing out your theory, we first need to talk about the difference between something in philosophy called ideal theory and nonideal theory. So can you help us understand the difference there?

Elizabeth Lanphier: So ideal theory and nonideal theory are about how we conceptualize justice. So they're specifically addressing questions of justice. And ideal theory, in a nutshell, would inquire into what an ideal society would look like even if that's not the society we live in, right? So what are the principles or the basic structures to use that would be required under ideal conditions to bring about an ideally just society?

Nonideal theory is kind of working from this other perspective of saying, "Well, what are we dealing with in society, recognizing that we don't live under these ideal structures?" And it's theorizing a little bit bottom up rather than top down, though they're both thinking about questions of justice and fairness, but starting from sort of different places in terms of how we get there.

Christiane: So you write that it's important to look at care ethics as a nonideal theory of justice. And why is that?

Elizabeth Lanphier: My interest in calling care ethics a nonideal theory of justice is a way of drawing care and justice into conversation with each other. And to say, again, taking a position on this sort of care-versus-justice historical tension to say, "Well, we need them in tandem." And there are going to be ways in which justice requires care, and provisions of care are both due to people out of justice-based concerns and we might have obligations to care for reasons related to justice. And so there's sort of this element of kind of recognizing that we're thrown into a whole bunch of contingent circumstances that impact the care resources to which we have basic access and recognizing that we have very different needs for care and that those will be different not only between individuals but for a given individual across their lifespan. And many of those needs are predictable, and some of them are going to be wildly unpredictable, right? So we know when we're born that we have certain needs for care, and we're reliant on others. I think that's really why parenting and family relationships are a very foundational way to think about care ethics. We also know that our needs for care will likely evolve over our lifetimes, and they're going to be based on all sorts of contingent factors related to our health, what may or may not happen to us accidentally or otherwise.

But recognizing that we exist in a world in which care is certainly not evenly or fairly distributed.

Christiane: So you just mentioned familial relationships. And so when I think of care ethics, that's where I go first, right, I'm a mother, and so especially, the mother-child relationship. But that's certainly not the only type of caregiving or care-receiving relationship, but I still sort of think of care ethics as being a very intimate thing. So how is it possible to have an institutional ethic of care, and what counts as an institution in your theory?

Elizabeth Lanphier: A lot of care ethics, as we've mentioned, continues to be modeled or has historically been modeled on, right, these intimate caring relationships. We can talk about different ways of caring, right? We might care *about* someone in terms of caring about what happens to them, caring about their wellbeing. We might care *for* someone in terms of having affection for them. "I care for you," right? That's sort of this idea that you have some interest in their life or their wellbeing, affection toward them. You might also just literally care for someone. You might provide physical care needs for them. I'm interested in the ways in which often we assume that caring about and caring for someone in these affective senses goes with caring for them in this tangible, practical sense, right?

I care about my child, and so I provide care for my child in ways that I maybe don't for other people's children, although I might be more inclined to care about children in general and then contribute care to organizations, let's say, that support children's welfare because I care about children, right? So I think there's that kind of emotional, affective, even intellectual connection we have for individuals that we might care for and care about. And then that contributes to our willingness to provide more material forms of care, frankly, to them. And I think that's a shortcoming, unfortunately, because a lot of us, right, might not have those kind of affective, caring relationships always or in the situations in which we really need them, but we still need to be cared for in this material, tangible sense. And so this is what I'm interested in, really this question of, does care need to be affective, or does it have to be about this language of cherishing or intimacy that we often associate with it in care ethics? Or could it be something else?

Here, again, I think healthcare is actually a great model because a lot of people that are cared for in healthcare settings are not intimately cared for. They're not necessarily cherished by the individuals caring for them. They don't have affective relationships between patients and the medical providers that are providing care, and yet this care is provided. And I think that actually kind of models ways in which we can actually disentangle the material forms of care and being cared for from these affective ideas of care. And that's what I'm really interested in, is how to think about opportunities–and it's not to say that all care should then become non-affective or not intimate–but I think that we actually have models for ways in which care can and is at times not about affective relationships or intimate kinship relationships and that those provided some real insight into ways in which we could or should be thinking about care differently from this institutional standpoint around how we actually create structures of care that can hopefully more

fairly and equitably, and this is where it comes back to justice, make sure people's caring needs are met.

Christiane: One of the components of care ethics that I am most fascinated by is the idea of paying attention to someone's needs in a care setting. You have this really interesting discussion about the difference between giving equal attention to everyone and then giving adequate attention to everyone. So what's the difference between those, and why does it matter?

Elizabeth Lanphier: I really love the work of Margaret Urban Walker and get this idea from her and her sort of exploration of what she calls partial considerations, the ways in which we might show partiality toward people. And that's not problematic, right? I think that there might be ways in which showing partiality in some circumstances would be accused of being relativist or unfair or biased. Again, in opposition to this, in sort of idealized sense of justice is everyone being treated equally and everyone having their equal, fair share of something. And what Walker does in this really interesting way is say, "Well, not everyone has the same basic needs and therefore shouldn't necessarily be due the same things." And so the point isn't to say, are you all getting the exact same size slice of pie, but, are you getting an adequate amount of pie to meet your needs? Right?

And so I think there's this great kind of idea that Walker introduces that I want to build on, around, what we can do is show appropriate attention to individuals such that we can adequately assess their needs and then respond to them. And so it's not to say that everyone is going to need the exact same care resources. It's to say, we're going to give everyone the equal opportunity or sort of adequate opportunity to have their needs for care assessed. And then we might actually supply differential amounts of care based on those needs. And that's completely fair. So we, right, aren't distributing care kind of in same-size tranches, for example, right? It's not the same size piece of pie, but it's saying, okay, who needs a slightly bigger piece of pie? Who needs less because they're getting more elsewhere? And so I think this is where this idea of training adequate attention on everyone to assess their care needs and then being able to, hopefully (though I don't think we live in this kind of world yet), meet those needs with appropriate care resources, even if it's not equal care resources.

Christiane: I can see how that could play out on an intimate level, right? I have two kids and so, I can sort of assess on a daily basis who maybe needs more touch, who maybe needs more food, things like that. But I just can't picture that working on an institutional level. So how would that... Well, I don't want to say in an ideal world, but how might that work out?

Elizabeth Lanphier: Well so I think what's been really fascinating over the last couple of years during the COVID pandemic is I think that there is actually a much better attention to the ways in which we're all reliant on care and do have an unequal distribution of care. So, you're right, it's easier in the two-person scenario, it's always easier in the two-person scenario or internal to a particular family, and then when we get into questions around caring for your two kids and making sure they have the right amount of food versus all the kids in our community having the

right amount of food, that can't be your burden alone. And it shouldn't be for you to figure out and think about and train attention to, though I think we could have systems within a community that make sure we're training attention on whether families are adequately resourced with food to meet their food needs. And that could be in the form of a municipal body that is doing surveillance and monitoring. It could be in the form of healthcare, catchment areas.

I think that there are mechanisms for doing that and saying, okay, so maybe some households aren't receiving adequate care through having their food needs met. And we can create systems to try to raise them up that maybe your family or my family doesn't need and doesn't require.

And it's not unfair to say, you're actually getting your care needs met when it comes to adequate nutrition in your household, and these other households are not. Right? I think that those are essentially social welfare programming. And so I think what's been interesting during the COVID pandemic, again, is the ways in which we've been, I think, as a society, more aware of how reliant we all are on care and how differential our resources are to access that care, right, whether it's recognizing that some families, when schools closed and daycare centers closed and all families had to rely on what was going on inside their own houses or apartments or shared communal living environments, wherever they might be, realizing how different the caring resources were internal to our own situations.

And so I think those kinds of things, right, put in stark relief how differently distributed basic access to caring goods are and then raise real questions about how we might support or sustain families. You don't think they were resolved, but things like the child tax credits, right, that's a program to say, okay, some families don't have the same resources as others. We could train our attention on this and try to raise up the caring resources of some households, recognizing that not all of them need it in the same ways.

Christiane: So can you give us an example of what care might look like within the framework of an institutional ethic of care?

Elizabeth Lanphier: Let's say, for example, a family comes to discover that their child is going to be, at least some of the time, dependent on a breathing machine to breathe at home. Healthcare can provide this, right? Healthcare is pretty amazing and the technology and the things that can do these days, and can help that child really survive and thrive and be ready to go home. But in order to go home, that family's going to need access to a whole host of resources that might include, right, a house that is set up in a way that is accessible, that has the right power requirements, that has the right configuration and space to accommodate the child and the needs for their medical equipment. They also might need access to around-the-clock caregiving. And that caregiving needs to be provided either by family and kinship, individuals or professionals, or some combination therein.

All of that costs money and resources, right? Whether it's the family choosing to, for example, forgo other work and maybe other obligations to other children in the household to provide that

care, or the ability to bring in outside help, it all comes down to a set of resources that people have different levels of access to. And so I think that one thing that's interesting to me is, if it's a society we're going to value these forms of healthcare and think that they ought to be provided to people, which I think we do, right, I think that we've decided as a society and as a medical community that we want people to be able to have those opportunities to continue to live healthy long lives and receive these forms of healthcare, we also need to figure out ways to provide the kinds of care that are then required to live that life. It's not just about what happens in the hospital that might be the life-saving intervention that puts someone on life support, but says, okay, so how do we then help these kids and these families have sustainable lives, recognizing that a lot of it comes down to material care resources essentially?

Christiane: Is there anything that you think we ought to cover that I didn't ask about?

Elizabeth Lanphier: I was thinking there was an article I recently saw. It was by a journalist who was talking about or talking to a variety of bioethicists about clinician, either obligations to provide abortion care or whether maybe clinicians ought to kind of conscientiously provide abortion care even in the face of these changing legislative landscapes around abortion in many states since the end of Roe v Wade. And the journalist had sort of concluded the piece with an observation that in many conversations about abortion, the language has turned to abortion "care."

And the journalist sort of said, "Well, that seems wrong because abortion is something that sometimes is just an individual making a choice for herself about abortion," right, "and that can be a selfish choice, and care is something we do for other people." And I thought that, well, that was so interesting and really made me wish that a care ethicist or a variety of care ethicists and not just bioethicists had been interviewed for this piece because I think that, right, even the idea that we might have the opportunities to care for ourselves in the ways we want to rely on these social systems and infrastructure to access that care, right? So the choice, for example, for someone, the ability for someone to choose abortion, even if they're going to self-manage it and they understand that, is entirely about something they're doing for themselves, relies, I think, on a whole vast infrastructure of care, whether it's healthcare resources, the ability to care for yourself in that way.

And so I thought it was so interesting, this kind of assumption around what is and isn't care. But I do think that to some extent, this idea of an institutional ethic of care is really saying, what are the background structures and conditions that allow for people to access the care they need and make the kind of choices around their care that are right for them? And recognizing that we might be limited in those choices because of institutional and systems related issues and that care isn't only, and often isn't only about individual choice, it's the ability to make those sets of choices, right? You know there's so much, I think, awareness around, again, self-managed abortions and abortion pills and this idea that people can take these matters into their own hands and aren't reliant, right, this idea that, well, maybe we don't need to be so reliant on healthcare providers and these other things. But even the availability of those medications is

about systems and structures and institutions and institutional regulation of abortion pills. And so I think to sort of, again, make it all about individual choice and individual practices really misses the bigger picture around access and justice that have to be part of our conversations about care. And care has to be about institutions and justice.

[Interview ends] **[music: Latché Swing, Songe D'Automne]**

Christiane: If you want to find more about our guest's other work, download a transcript or learn about some of the things we mentioned in today's episode visit prindleinstitute.org/examining-ethics.

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