Original Manuscript

Nursing Ethics
1–10

10.1177/0969733015624475
nej.sagepub.com

Against dichotomies: On mature care and self-sacrifice in care ethics

Inge van Nistelrooij and Carlo Leget
University of Humanistic Studies, The Netherlands

Abstract

Introduction: In previous issues of this journal, Carol Gilligan's original concept of mature care has been conceptualized by several (especially Norwegian) contributors. This has resulted in a dichotomous view of self and other, and of self-care and altruism, in which any form of self-sacrifice is rejected. Although this interpretation of Gilligan seems to be quite persistent in care-ethical theory, it does not seem to do justice to either Gilligan's original work or the tensions experienced in contemporary nursing practice.

Discussion: A close reading of Gilligan's concept of mature care leads to a view that differs radically from any dichotomy of self-care and altruism. Instead of a dichotomous view, a dialectical view on self and other is proposed that builds upon connectedness and might support a care-ethical view of nursing that is more consistent with Gilligan's own critical insights such as relationality and a practice-based ethics. A concrete case taken from nursing practice shows the interconnectedness of professional and personal responsibility. This underpins a multilayered, complex view of self-realization that encompasses sacrifices as well.

Conclusion: When mature care is characterized as a practice of a multilayered connectedness, caregivers can be acknowledged for their relational identity and nursing practices can be recognized as multilayered and interconnected. This view is better able to capture the tensions that are related to today's nursing as a practice, which inevitably includes sacrifices of self. In conclusion, a further discussion on normative conceptualizations of care is proposed that starts with a non-normative scrutiny of caring practices.

Keywords

Dichotomy of self and other, ethics of care, Gilligan, mature care, relational identity, relationality, self-sacrifice

Introduction

This article aims to contribute to a discussion on normative conceptualizations of care that has been developed in this journal from 2011 onward. It especially challenges the interpretation of the concept of mature care as reciprocity as elaborated in two papers by the Norwegian scholars Pettersen, Hem, Halvorsen, and Nortvedt.[1,2] They understand mature care, a term coined by Carol Gilligan,[3] as the highest level of moral development in a morality that is characterized by care rather than by justice. Drawing especially upon the philosophical work of Pettersen,[4–7] Pettersen and Hem[1] interpret mature care as reciprocity and

Corresponding author: Inge van Nistelrooij, University of Humanistic Studies, Kromme Nieuwegracht 29, 3512 HD Utrecht, The Netherlands.
Email: i.vannistelrooij@uvh.nl

apply it to two cases from acute psychiatry. They argue that the practice of care (as in nursing) can best be conceptualized when reciprocity is taken as crucial. By emphasizing reciprocity, Pettersen and Hem oppose views that consider caring as a one-sided activity that has a single main source of knowledge and motivation: either the caregiver or the care receiver (p. 217).

In another Norwegian contribution, Nordhaug and Nortvedt criticize the idea of mature care in relation to professional care.[8] They consider the idea of balancing the needs and interests of the caregiver against those of the care receiver inappropriate for professional care, because this care takes place "in asymmetrical relationships in which professionals' concern should be directed towards patients and not vice versa" (p. 210).[8] This objection, however, is not taken into account in a recent elaboration of mature care by Hem et al.[2] Rooted again in Pettersen's work,[4–7] these authors argue that the concept of mature care offers theoretical resources to capture challenges in today's nursing by counterbalancing the traditional altruistic approaches to caring. Exploring the similarities between mature care and virtue ethics they argue that these provide fruitful grounds for a further development of theories on mature care as a contribution to normative discussions about care (p. 795).[2]

Aim

This article addresses this discussion and critically investigates the concept of mature care. It aims to show that there is a considerable difference in how Gilligan discusses the concept in her theoretical framework of a care morality, on one hand, and how she discusses it in her representation and interpretation of her empirical findings, on the other—most especially those findings that arise in real-life reflections of women deliberating a concrete moral decision (namely, an abortion). Gilligan's conceptualization that takes empirical findings into account appears as less dichotomous, more complex and multilayered than her theoretical conceptualization. In the recent discussion, however, the interpretation of the concept of mature care is mainly based on Gilligan's theoretical framework. This leads to an inconsistency in these texts, which consists in simultaneously proposing both a separation between self and other and a relational ontology (i.e. a view that advocates that a human being is essentially relational, hence not separated from the other). Defending a relational ontology, however, seems to be irreconcilable with the separation advocated.

Discussion: mature care and self-sacrifice

Mature care in Norwegian care ethics

Since the care-ethical conceptual start with Gilligan's *In a Different Voice*,[3] an ongoing debate has taken place on the interpretation of care.[5–20] Special attention has been given to the relation between self and other as described in the third stage of her model of moral development, that is, the stage of mature care.[1,2,4–8] Norwegian scholars have taken the concept of mature care to oppose the idea of altruistic care that they consider dominant in Norwegian educational nursing textbooks.[1,2,4–7,21,22] It is argued that mature care resembles the Aristotelian "golden mean" as it is a mean between too little and too much care for the self respectively for others.[1,2] They explicitly call upon reciprocity and mutual recognition as correctives to any one-sidedness of caregiving, which can consist in either self-sacrifice or self-denial, or in narrowly particularistic and self-centered concern (pp. 56–57).[1]

In their reflection on mature care, Pettersen and Hem[1,2] draw upon Gilligan's work,[3] which they consider a source of inspiration for nurses. Especially valuable is the care-ethical emphasis on human interdependence and vulnerability as core traits of human existence.[2] Gilligan's introduction of the concept of mature care, revitalized about 20 years later,[1,2,4–7] is considered as "a supplementary or even alternative normative

framework for an ethics of care in nursing."[2] This alternative is a necessary counterbalance to the altruistic component of care which tends to be overemphasized in our culture leading to an appraisal of caregivers' self-sacrifice (p. 210).[1]

The concept of mature care is represented as follows. Its core idea is to convey a relational ontology into the normative concept of care (p. 218).[1] Thus, reciprocity appears as the normative basis of care instead of any one-sidedness from the part of the caregiver (pp. 218–219).[1] Mature care is proposed as "a demanding ideal" that "can be challenging to practice" (p. 221).[1] Pettersen and Hem illustrate their point by applying this ideal to two cases from acute psychiatry. Nurses are invited to apply the concept of mature care also in these particular cases of obvious asymmetry (p. 224).[1] In these cases, the patient cannot be expected to act as a mature carer, but still can be encouraged to develop reciprocity and contextual sensitivity that are useful skills in other relationships as well (p. 224).[1] Nurses, if possible, can help in establishing reciprocal relationships, for which the ideal of mature care is a valuable guide (p. 229).[1]

The 2014 article further elaborates upon the concept by illuminating the mature self–other-relation as opposed to altruism. Mature care puts "a more systematic focus also on the perspective and motivations of the professional carer," who "must know herself to be a good carer" (p. 797).[2] The asymmetry of the nurse–patient relationship is founded upon the fact that "the responsibility for providing assistance and care is with the nurse" (p. 797).[2] It is, however, exactly on this point that the concept of mature care can prove its value in order to "prevent the carer from becoming so absorbed in the one particularly needy that the obligations she has towards herself and others are neglected" (p. 797).[2] Since professional care work involves intimacy in the physical, emotional, and existential sense, caring is demanding work which requires self-reflection in order to have boundaries:

> The challenge for the carer is to have boundaries because without being an "I," or to be "someone," one has nothing with which to meet the other. The theory of mature care can help understand this crucial aspect of being a carer. (p. 797)[2]

This setting of boundaries by the carer is put opposite of the tendency of many, observed by the authors, to argue for altruistic care as the ideal type, "meaning caring as a spontaneous, selfless and unconditional action, which might require some degree of self-sacrifice, and which is given to a particular person with a need and given for the sake of the other" (p. 797).[2] The authors are especially concerned with our culture that "seems to provide greater moral credit for an agent to extend to the other and sacrifice her own needs than to fulfil one's own needs and interests" (p. 797).[2]

The counterbalance is offered by the concept of mature care that by stressing reciprocity prevents "boundless and self-sacrificing caring," helps "[r]eflecting, balancing interests and setting limits," promotes the value of equality, and helps carers "to protect themselves and keep a healthy emotional balance" (p. 798).[2]

Hence, the main concern that prompts this interpretation of mature care seems to be the risk that lies in neglect, undervaluation or underestimation of the self, in boundless and self-sacrificing care for others, in inequality and harm of the self. This concern asks for a balance between self and other, care given to self and other, the interests of the self as opposed to those of the other, in short between egoism and altruism. This opposition of egoism and altruism as well as the search for a middle between these extremes reflects a dichotomous view of self and other, that is further expressed in terms like "parties,"[1] "limits,"[1,2] "having boundaries,"[2] "balancing interests and concerns for self and concerns for other"[2] which are used throughout these works.

The question remains, however, whether this idea of mature care is adequate to capture tensions, complexity, and ambiguities that are inherent to (professional) caring practices. An indication that perhaps it is not was given by Nordhaug and Nortvedt.[8] They stress that in professional caring practices, the

emphasis on reciprocity needs to be reduced because of the legitimate needs of patients and the professional's "primary duty to meet their medical and caring needs." They plea for space in which altruism and partiality are admirable and no harmonization can be reached (p. 215).[8] Other scholars have taken various stances as well with regard to the (non-)balance and (non-)harmonization between the self and the other. This can be demonstrated when their views on self-sacrifice are scrutinized.

Other care-ethical stances on non-balance and self-sacrifice

From its very beginning, many pioneers in the ethics of care have sought for a balance between care for the self and care for the other and have criticized the idea of self-sacrifice. Joan Tronto,[11] for instance, acknowledges that certain one-sidedness seems to be inherent to care, as a practice that reaches out to something other than the self (p. 102).[11] Nevertheless, she aims to keep a balance between the needs of caregivers and care-receivers (p. 136).[11] This leads to the problems of evaluating proper levels of care inherent to the nature of care (p. 141).[11] Tronto mentions sacrifice and self-sacrifice in relation to these evaluation problems, but the issue that she puts central is the problem of equality. She argues,

> Some people make greater sacrifices of themselves than do other people; some will even sacrifice too much. Part of this moral problem is exacerbated by the fact that those who are most likely to be too self-sacrificing are likely to be the relatively powerless in society. (p. 141)[11]

Hence, sacrifice and self-sacrifice appear not as reprehensible per se, but only when they lead to imbalance. Imbalance and power inequality are the real problem, not self-sacrifice.

Other scholars,[10,18,23–25] however, have de-emphasized the idea of a balance and have not rejected self-sacrifice strongly. Several of them even do not problematize self-sacrifice, but rather mention it as a tendency within caring practices. Sara Ruddick,[10] for instance, uncovers self-sacrifice as one of the temptations inherent in "mothering" (p. 30).[10] Ruth Groenhout[23] admits that self-sacrifice has been rejected by women as it has been considered to be a part of the oppressive ideology that connects women to caring for others while denying one's own talents and future prospects for the sake of another (pp. 154–155).[23] However, she also defends that ethical theories have always required a denial of self-interest at some level (p. 154).[23] She unfolds a taxonomy of self-sacrifice that is a sliding scale of its distinct meanings. It ranges from self-limitation, giving up of prerogatives, self-giving, to self-sacrifice (pp. 297–298).[24] Throughout this sliding scale, one's core identity is increasingly set aside or denied for the sake of another part, and ultimately the self or one's life is literally given up or sacrificed (p. 298).[24] Up to this point, self-sacrifice is not morally rejected. The line is drawn where the self is sacrificed for its own sake, which is mere self-destruction. The distinction between self-sacrifice and self-destruction depends upon two criteria: first, the self that is sacrificed must be recognized as a self with intrinsic value; second, a proper self-sacrifice is oriented toward the good.[23,24]

Annelies van Heijst's concept of "Professional Loving Care" (PLC, as an alternative to "Tender Loving Care," TLC) emphasizes the vulnerability and preciousness of both the caregiver and the care-receiver.[18] Nevertheless, she sees a place for self-sacrifice within care, albeit a limited and conditional one:

> Only when one gives up time and energy freely, driven by a sincere commitment for the person concerned and by feelings of professional responsibility are self-sacrificial acts not harmful. (p. 197)[18]

Here too, self-sacrifice is not downright rejected, but conditionally accepted and even considered as part of the dynamics of giving and receiving care, in which not every gift requires a return gift. The full dynamics of giving and receiving in professional caregiving is not one of exchange and fulfillment, but leaves room for giving as meaningful in itself.

These authors do not reject self-sacrifice within practices of care from the outset, not even in professional practices. Rather, from their works a more complex, even ambiguous and richer view of care practices emerges. But how does this relate to the idea of mature care in Gilligan's work?

Gilligan on mature care and self-sacrifice

In Gilligan's work, the term self-sacrifice is used, be it in various ways. Reading Gilligan's book closely results in the observation that the self–other-tension as well as the fierce resistance against self-sacrifice transforms when Gilligan shifts from her theoretical framework to the results of her empirical research. In these latter accounts, the dichotomy between self and other is replaced by a different account of self and other. The tension between the two is no longer dissipated in mature care, but is rather transferred to the inside of the carer. The caregiving morality is not characterized by seeking a balance between self and other, but rather by a much more complex, multilayered, ambiguous acceptance of inevitable harm. Let us take a closer look now at Gilligan's work.

Theoretical model

When Carol Gilligan[3] describes the moral development of the "different voice" of a morality of care, she frames this morality as one that circles around the conflict between self and other:

> The conflict between self and other thus constitutes the central moral problem for women, posing a dilemma whose resolution requires a reconciliation between femininity and adulthood. (pp. 70–71)[3]

Although in her empirical work Gilligan mainly found this voice with women, she did not exclusively so. She criticizes those models that have derived their categories for assessing the development from research exclusively performed on men. These models, after all, have considered divergence from these masculine standards as a failure of development (pp. 69–70).[3] Gilligan[3] has therefore sought for alternative criteria that might better encompass other developments than only that of men (p. 70). She researched the experiences of the self and of morality of women, for instance, those women who were deciding about having an abortion or not. These women were interviewed about both the decision they faced and three hypothetical dilemmas, including the Heinz dilemma from Kohlberg's research (p. 72).[3] From these interviews, she gained insight into how these women conceptualized their selves as well as morality.

As Gilligan found out, the concept of the self is characterized by a dichotomy. On one hand, these women have been given the right to control their fertility and decide about abortion through which "the dilemma of choice enters a central arena of women's lives" (p. 70).[3] Through this right, society has given women the public mark of adulthood, that is, the right to choose for themselves and to exercise such choice. On the other hand, the conventions of femininity make women's care and concern for others the measure by which they are judged by others and judge themselves (p. 70).[3] The conceptualization of their selves is thus marked by the ambiguity of femininity and adulthood (pp. 76, 90).[3]

The concept of morality mirrors this dichotomy. Moral conflicts arise as "the conflict between compassion and autonomy, between virtue and power" (p. 71).[3] As many respondents have expressed the wish not to hurt anyone as a moral guideline for themselves (cf. pp. 64–69),[3] moral dilemmas are mainly experienced when the wish to reclaim the self is in conflict with the wish not to hurt others. A moral thinking in terms of rights and rules (i.e. the conceptualization of morality as justice) then opposes a moral understanding in terms of responsibility and relationships (p. 73).[3] The former is mainly put in terms of selfishness, the latter in terms of care:

> Women's constructions of the abortion dilemma in particular reveal the existence of a distinct moral language whose evolution traces a sequence of development. This is the language of selfishness and responsibility, which defines the moral problem as one of obligation to exercise care and avoid hurt. The inflicting of hurt is considered selfish and immoral in its reflection of unconcern, while the expression of care is seen as the fulfillment of moral responsibility. (p. 73)[3]

From the interviews, Gilligan derives a model of moral development as a sequence of three perspectives with transitional phases between them. With this staged model she follows Lawrence Kohlberg's staged model of moral development, which in turn was an extension of Piaget's description of children's moral judgment. Kohlberg describes the development of the argumentative capacity to reason from a justice perspective, and Gilligan's search for alternative criteria results in the description of the argumentative capacity to reason from a care perspective (pp. 72–73).[3] In the initial preconventional stage, the focus is on caring for the self, followed by a transitional phase in which this judgment is criticized as selfish (p. 74).[3] A new understanding of the connection between self and others is articulated by the concept of responsibility in the second, conventional, stage, which leads to the equation of the moral good with caring for others (p. 74).[3] The concept of responsibility, however, leads to a "disequilibrium that initiates the second transition" after which the third, postconventional, stage is reached (p. 74).[3] The disequilibrium consists in "the confusion between self-sacrifice and care [that is] inherent in the conventions of feminine goodness," Gilligan argues (p. 74).[3] In the transition, this confusion is sorted out and the third, postconventional, perspective is reached:

> The third perspective focuses on the dynamics of relationships and dissipates the tension between selfishness and responsibility through a new understanding of the connection between other and self. Care becomes the self-chosen principle of a judgment that remains psychological in its concern with relationships and response but becomes universal in its condemnation of exploitation and hurt. (p. 74)[3]

Hence, in a few pages, Gilligan sketches the development of an ethic of care which is reached, thanks to cumulative knowledge about human relationships and has as central insight that self and other are interdependent (p. 74).[3] Understanding this interdependency leads to the rejection of both violence toward others and toward the self in self-sacrifice. Care enhances both self and other, Gilligan claims (p. 74).[3]

Empirically informed mature care

An interesting alternation takes place when Gilligan turns from her theoretical model of moral development to the results of her empirical research among women deciding about having an abortion. Not only does the theoretical model gain substance from this women's concrete life experience, but the tension between self and other, and her view of self-sacrifice changes as well. The third developmental stage of mature care is no longer marked by the dissipation of the tension between self and other, but this tension is transferred to the inside of the identity of the one making the moral decision. This transfer should not be taken literally with regard to the woman carrying her child inside her body, but should be taken as a weighing of the goods of self and other which are inescapably bound up with the woman's own identity. Interestingly, self-sacrifice appears as a more ambivalent term from this point onward.

The moral development of the respondents, then, is described as follows. In the first stage the women's argument for having their abortion centers around the self as the sole object of concern. "Should" and "would" are the same thing, these women say, as the question of the right decision is answered by the mere wish not to have the baby (p. 75).[3] In the transitional phase that follows, the question of selfishness versus responsibility is asked and a turn is made toward connection and attachment to others (p. 76).[3] This leads to the second perspective in which selfishness is juxtaposed to responsibility. An understanding of conventional adult feminine roles arises and the moral problem is cast in terms of a conflict between wish and

necessity, between independence and connection, between freedom and responsibility (pp. 76–77).[3] The coin then is flipped over to the other side: ''selfishness'' is exchanged for forgetting what one would choose for the self. The pressure exerted by the wish not to hurt anyone and by the feminine identification of goodness with self-sacrifice lead women to argue for their abortion in ways that avoid responsibility for the choice that is made (pp. 80–81).[3] The abortion for instance takes place for the sake of not hurting the father or his wife (!) and is defended as a sacrifice of the woman's own needs for those of others (p. 81).[3] The next transitional phase involves ''a shift in concern from goodness to truth'': the woman begins to scrutinize ''the logic of self-sacrifice in the service of a morality of care'' (p. 82):[3]

> In the abortion interviews this transition is announced by the reappearance of the word *selfish*. Retrieving the judgmental initiative, the woman begins to ask whether it is selfish or responsible, moral or immoral, to include her own needs within the compass of her care and concern. This question leads her to reexamine the concept of responsibility, juxtaposing the concern with what other people think with a new inner judgment. (p. 82)[3]

The first demand of this new understanding of responsibility is honesty: not goodness but truth is required in order to exercise responsibility in a morality of action (pp. 82–83).[3] The respondents express no longer a concern with selfishness, but a concern with honesty and truth (p. 84).[3] They use words like being ''fair to myself'' and ''truthful, not hiding anything, bringing out all the feelings involved,'' making an ''honest'' decision (pp. 84–85).[3] Gilligan argues that this is the essence of this transitional shift, in which goodness is no longer a movement outwards, but inwards as well, in acknowledging the self and in accepting responsibility for choice (p. 85).[3] Conflicts arise that are internal as well, for instance, when a woman experiences the tension between her capacity to recognize and meet the needs of others and her pursuit of professional advancement (p. 97).[3] This honest representation of her ''going in two directions'' reflects a more adequate morality than one that puts the problem as a conflict between the wish of herself versus the wish of others (pp. 96–97).[3]

Contrary to the theoretical presentation of her model in which the tension between self-sacrifice and selfishness dissipates in the third perspective, Gilligan does not mention the disappearance or solution to the tension when describing the experiences of women when deciding about abortion. The search for truth and honesty rather seems to reveal tensions as more complex since they are internal tensions and not oppositions between the self and others. Therefore, the tension becomes multilayered and one needs to face the inescapability of someone getting hurt, of a sacrifice on one part or the other. Any reliance on a morality based upon ''the concept of the separate self and of moral principles uncompromised by the constraints of reality'' is viewed as ''an adolescent ideal'' (p. 98).[3] A mature morality and a mature moral judgment are not cast in terms of rights, but in terms of responsibility and care, when explaining what is considered as a moral issue (p. 99).[3] As one respondent argues,

> When I am dealing with moral issues, I am sort of saying to myself constantly, ''Are you taking care of all the things that you think are important, and in what ways are you wasting yourself and wasting those issues?'' (p. 99)[3]

The women are also asked to reflect upon hypothetical dilemmas such as the Heinz dilemma taken from Kohlberg's research. Heinz is considering to steal a drug that he cannot afford in order to save his wife's life (p. 25).[3] The women interviewed reconstruct the dilemma in terms of the real; they ask to provide missing information about the nature of the people and the places where they live (p. 101).[3] This alters the dilemma itself. Heinz, according to the women, needs to choose between selfishness and sacrifice: stealing means being imprisoned and thereby making the sacrifice of freedom, ''a sacrifice which I would say a person truly in love might be willing to make,'' as one woman puts it (p. 101).[3] The other option would be selfish and create a sense of guilt. Gilligan's interpretation of these answers, however, differs from ours. First, Gilligan sees the women construct a choice between opposite lives, opposite interests:

> Its resolution has less to do with the relative weight of life and property in an abstract moral conception than with the collision between two lives, formerly conjoined *but now in opposition*, where the continuation of one life can occur only at the expense of the other. This construction makes clear why judgment revolves around the issue of sacrifice and why guilt becomes the inevitable concomitant of either resolution. (p. 101, emphasis added I.v.N.)[3]

Opposed to this interpretation, we would argue that the respondents did not express this opposition of lives. Rather, if stealing and sacrificing his freedom was the sacrifice that Heinz was willing to make as an act of true love for his wife, as one respondent expressed, one could say that this is an expression of his love, a realization of himself as a husband inducing him to prefer her life to his freedom. And if not, stealing would indeed create a sense of guilt, and this can be taken as an indication of a sense of connectedness rather than of opposition.

Gilligan's interpretation leaves aside the possible interconnectedness of Heinz with his wife, where she did take this into account in her analysis of the real-life abortion deliberation. When closely examining the respondents' expressions, the picture changes. What remains in how the moral dilemmas, even the hypothetical ones, are understood in terms of concrete and related lives, is that moral questions involve sacrifice and guilt as inescapable in the choices life forces upon people.

Discrepancy between Gilligan's theoretical and empirically informed concept of mature care

Reading Gilligan carefully and critically, one cannot but conclude that there is a discrepancy between the theoretical presentation of her developmental model, in which the tension between self-sacrifice and selfishness is dissipated; and her representation of the views of women facing a moral decision in their actual lives and reflecting upon hypothetical moral dilemmas. In their experience, this tension is not dissipated but the gray is discovered. As one of the interviewed women, a Catholic nurse who has reflected upon her actual experiences with euthanasia and now faces the decision about abortion, puts it,

> You really don't know your black and whites until you really get into them and are being confronted with it. If you stop and think about my feelings on euthanasia until I got into it, and then my feelings about abortion until I got into it, I thought both of them were murder. Right and wrong and no middle, but there is a gray. (p. 87)[3]

Discovering the gray leads to the reconsideration of moral judgments that were formerly believed to be absolute (p. 87). Gilligan herself does not draw attention to this discrepancy. We, however, believe it central to the care-ethical epistemological claim that practices are the primary source of moral knowledge. It is through living together with other people and acting together in collective practices that we learn about ourselves and about moral goods, like Margaret Urban Walker has argued in her epistemological work on the "collaborative-expressive model of morality."[13] When looking deeply into caring practices, other than dichotomous images of care emerge. Therefore, a picture of mature care that upholds a dichotomy of self and other is inadequate and even runs the risk of being irrelevant for professional caring practices. This statement can be underpinned not only with Gilligan's own work but also by Van Heijst's work on *PLC*.

PLC and the rejection of dichotomies

When criticizing ethical theorists who do not have their views informed by caring practices, Annelies van Heijst[18] presents an interesting case (pp. 181–199). She reports a real-life example of five district nurses taking care of a woman who lies dying in her home and has nobody else to support her. Although they are not supported by their institution, they consider it their professional and personal responsibility to not let this woman die alone. Therefore, they take turns in 24-h-shifts and eventually the woman dies with one of the nurses present. Although the women themselves do not consider this a case of self-sacrifice, Van Heijst

explains, they do dedicate lots of their free time to this case. After the woman's death, the nurses confront their institution with the bill of their over-time. The bill is paid by the institution, although the nurses are told to keep quiet in order not to damage the institution's image (p. 183).[18]

A practice-based ethics of care, according to Van Heijst,[18] uncovers how care is relationally based and institutionally mediated, since the nurses saw the dying woman "as a client and as a fellow-human being in distress, whom they should not leave on her own" (p. 187). They not only spent their free time, making a personal investment as well as realizing their professional ideals, but they also tried to change the care policy of their organization by presenting their bill as a statement about appropriate care (pp. 187–188).[18] Hence, Van Heijst[18] argues for a new conceptualization of care that surpasses classic categories and moral boundaries between public versus private and professional versus personal:

> We need new concepts to describe the mix of distance and closeness that is going on between professionals and patients and clients in their care, for the long—or short—periods of time in which they interact. Both parties are strangers to each other and yet there is closeness and bonding, which is both more distant and more intimate than what goes on between friends, lovers, spouses, or parents and their children. (p. 188)

We agree with Van Heijst in her plea for new concepts.[25] Classic categories that create separation or opposition, like egoism versus altruism, self versus other, professional versus personal, self-sacrifice versus self-realization, are inadequate and impede a rich view of what caring is about. Taking the care-ethical critical insights of relationality, affectivity, contextuality, and practice-based morality seriously into account leads to a view of care that is able to see and understand ambiguities, ambivalences, tensions, and conflicts, rather than advising a one-sided, unrealistic moral stance. As such is it better suited to improve practices of caring.

Conclusion

The aim of this article was to challenge an interpretation of mature care including some dichotomies proposed by some Norwegian authors. Having presented a close reading of Carol Gilligan's work on mature care, we have demonstrated that this concept does not draw upon a dichotomy between self and other. Instead, a more complex and multilayered view of relationality can serve to capture tensions in nursing practices in a non-reductionist and non-simplifying way. This approach proposes a different view of ethics that draws upon practices rather than a comparison to virtue ethics, as Hem et al.[2] have suggested. For a practice-informed, rather than a virtue-informed, care ethics is better able to include both the needs of others and the mediation offered by institutions in its conceptualization of care.

Acknowledgements

The authors would like to thank our colleague Alistair Niemeijer for his valuable comments on drafts of this article and the anonymous peers for their helpful reviews.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

1. Pettersen T and Hem MH. Mature care and reciprocity: two cases from acute psychiatry. *Nurs Ethics* 2011; 18: 217–231.
2. Hem MH, Halvorsen K and Nortvedt P. Altruism and mature care: some rival moral considerations in care ethics. *Nurs Ethics* 2014; 21: 794–802.
3. Gilligan C. *In a different voice: psychological theory and women's development*. Cambridge, MA: Harvard University Press, 1982.
4. Pettersen T. *Comprehending care: problems and possibilities in Carol Gilligan's ethics of care*. PhD Thesis, University of Oslo, Oslo, 2004.
5. Pettersen T. *Comprehending care: problems and possibilities in the ethics of care*. Lanham, MD: Lexington Books, 2008.
6. Pettersen T. The ethics of care: normative structures and empirical implications. *Health Care Anal* 2011; 19: 51–64.
7. Pettersen T. Conceptions of care: altruism, feminism and mature care. *Hypatia* 2012; 27: 366–389.
8. Nordhaug M and Nortvedt P. Mature care in professional relationships and health care prioritizations. *Nurs Ethics* 2011; 18: 209–216.
9. Noddings N. *Caring: a feminine approach to ethics and moral education*. Berkeley, CA: University of California Press, 1984.
10. Ruddick S. *Maternal thinking: toward a politics of peace*. Boston, MA: Beacon Press, 1989.
11. Tronto JC. *Moral boundaries: a political argument for an ethic of care*. New York: Routledge, 1993.
12. Kittay EF. *Love's labor: essays on women, equality, and dependency*. New York: Routledge, 1999.
13. Conradi E. *Take care: Grundlagen einer Ethik der Achtsamkeit [Foundation of an Ethics of Attentiveness]*. Frankfurt am Main: Campus, 2001.
14. Walker MU. *Moral understandings: a feminist study in ethics*. New York: Oxford University Press, 2007 (original 1998).
15. Brugère F. *L'éthique du «care» [The ethics of 'care']*. Paris: Presses Universitaires de France (PUF), 2010.
16. Barnes M. *Care in everyday life: an ethic of care in practice*. Bristol: The Policy Press, 2012.
17. Leget C, Gastmans C and Verkerk M. *Care, compassion and recognition: an ethical discussion: ethics of care series*, vol. 1. Leuven: Peeters, 2011.
18. Van Heijst A. *Professional loving care: an ethical view of the health care sector—ethics of care series*, vol. 2. Leuven: Peeters, 2011.
19. Tronto JC. *Caring democracy: markets, equality, and justice*. New York; London: New York University Press, 2013.
20. Olthuis G, Kohlen H and Heier J. (eds) *Moral boundaries redrawn: the significance of Joan Tronto's argument for political theory, professional ethics, and care as practice—ethics of care series*, vol. 3. Leuven: Peeters, 2014.
21. Hem MH and Pettersen T. Mature care and nursing in psychiatry: notions regarding reciprocity in asymmetric professional relationships. *Health Care Anal* 19(1): 65–76.
22. Hem MH. Mature care—a conceptual, empirical and critical evaluation. *Presentation at the working conference "Ethics of Care as a Multidisciplinary Enterprise*," Utrecht, 1–3 November 2012, http://ethicsofcare.org/wp-content/uploads/2012/11/marit-helene-hem-ethics-of-care-conf-2012.pdf (2012, accessed December 2014).
23. Groenhout RE. I can't say no: self-sacrifice and an ethics of care. In: Groenhout RE and Bower M (eds) *Philosophy, feminism, and faith*. Bloomington, IN; Indianapolis, IN: Indiana University Press, 2003, pp. 152–174.
24. Groenhout RE. Kenosis and feminist theory. In: Evans S (ed.) *Exploring kenotic Christology: the self-emptying of god*. Oxford: Oxford University Press, 2006, pp. 291–312.
25. Van Nistelrooij I. *Sacrifice: a care-ethical reappraisal of sacrifice and self-sacrifice*. Leuven: Peeters, 2015.