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Scientific Contribution

The care perspective and autonomy

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Abstract. In this article I wish to show how care ethics puts forward a fundamental critique on the ideal of independency in human life without thereby discounting autonomy as a moral value altogether. In care ethics, a relational account of autonomy is developed instead. Because care ethics is sometimes criticized in the literature as hopelessly vague and ambiguous, I shall begin by elaborating on how care ethics and its place in ethical theory can be understood. I shall stipulate a definition of care ethics as a moral perspective or orientation from which ethical theorizing can take place. This will mean that care ethics is more a stance from which we can theorize ethically, than ready-made theory in itself. In conceiving care ethics in this way, it becomes possible to make clear that, for instance, a moral concept of autonomy is not abandoned, but instead is given a particular place and interpretation. In the final part of this article I will show how 'relational autonomy' can be applied fruitfully in the practice of psychiatric care.

Key words: autonomy, care ethics, compassionate interference, ethical theory, psychiatry

Introduction

Care ethics is sometimes seen as an ethical orientation which has no place for a concept such as autonomy. In a care perspective, understood as a relational perspective, the notion of individual autonomy is criticized as fundamentally individualistic. In this article I wish to show how care ethics puts forward a fundamental critique on the ideal of independency in human life without thereby discounting autonomy as a moral value altogether. In care ethics, a relational account of autonomy is developed instead.

Because care ethics is sometimes criticized in the literature as hopelessly vague and ambiguous, I shall start by elaborating on how care ethics and its place in ethical theory can be understood. I shall stipulate a definition of care ethics as a moral perspective or orientation from which ethical theorizing can take place. This will mean that care ethics is more a stance from which we can theorize ethically than a ready-made theory in itself. In conceiving care ethics in this way, it becomes possible to make clear that, for instance, a moral concept of autonomy is not abandoned, but instead is given a particular place and interpretation. After having explored the meaning of this concept of 'relational autonomy', I shall try to show briefly in the last paragraph the practical implications of using this notion of 'relational autonomy' in the context of social psychiatric care.

What is care ethics anyway?

Since Carol Gilligan's publication *In a different voice* (1982) , a vast amount of literature on care ethics has been developed. Part of this literature gives expression to the idea of care ethics as the articulation of important moral experiences which has been silenced in the history of philosophy and ethics. But there are others who view care ethics as an object of suspicion. They consider care ethics as 'nothing new', superfluous and dangerous. The discussion between these two parties is even made more difficult by the fact that there is a lot of confusion about what care ethics is and what contributions it has to make to the field of ethics and moral theory. At the outset I want to dismiss two misunderstandings about care ethics. A first misunderstanding is the idea that care ethics is a form of applied ethics, more specifically, as a type of ethics relevant to healthcare decision making. It thereby distinguishes itself from other forms of bioethics in its emphasis on concepts of care and caring. In this respect, care ethics is often indistinguishable from so-called nursing ethics. Now, although it is certainly true that nursing

ethics does make use of insights from care ethics, the two cannot be equated. The claims it makes are much more ambitious than simply being a form of applied ethics.

Another misunderstanding about care ethics is the idea that it provides a self-contained ethic adequate to some sphere of moral life. For instance, an ethics of friendship or an ethics of personal relationships are put forward as candidates for such an ethics of care. This interpretation is at home with all those other approaches in which an ethics of care is given a place next to the so-called ethics of justice in the moral scheme. Some deny the moral importance of a care ethics: it is not a moral perspective, but solely a personal one. Others plead for the adding of elements of care ethics to an ethics of justice in order to develop a more balanced ethics (Held, 1993; Ruddick, 1989). There are also those who regard perspectives as suitable to different moral contexts. Care should belong to the more personal sphere, in which agent-relative reasoning is appropriate and justice should be more at home in the large-scale and institutional contexts, in which agent-neutral reasons are the most appropriate ones. Finally, there are theorists, for instance Joan Tronto in her book *Moral Boundaries* (1993), who stress the idea that the split care and justice, or the moral boundary between a more abstract moral point of view of justice and the more engaged and particularistic moral point of view of care, should itself be questioned. As Tronto says, we cannot perceive care as a central aspect of human life as long as we leave current moral boundaries in place. Although the discussion about the proper place of an ethics of care in the ethical discourse still goes on and is not yet settled, I think that an ethics of care is more ambitious in its claims than to be solely an ethics of personal relationships.

But if care ethics is not a form of applied ethics, and if it cannot be considered as an ethics of personal relationships, what is it then? We can pose this question in even more annoying terms: Is care ethics, after all, really an ethics?[1] Perhaps it can be best presented as a moral perspective or orientation than as a full-blown ethical theory. For instance, in a recent article in the *Journal of Philosophy and Medicine* (1998), Margaret Olivia Little understands care ethics first and foremost as an orientation or perspective to the moral world. The care perspective is defined in term of *emphases of concern and discernment* (to notice and worry more, say, about the dangers of abandonment rather than the dangers of interference), *habits and proclivities of interpretation* (the proclivity, say, to read 'the' moral question presented by a situation in terms of responsibilities rather than rights) and *selectivity of skills* (to have developed, say, an attunement to difference than an ease of abstraction). Little stresses the idea that care ethics is more a stance from which to theorize, rather than a ready-made theory in itself. Although this will sound to some as too modest a claim on behalf of care ethics, I think that Little makes an important point here. For instance, care ethics has been criticized because its claims are either too broad or too narrow. In claiming that we should care for each other, it urges either expansive obligations to the world at large or it remains too parochial in its responsibilities. But as Little points out, 'the truth is that the care orientation in and of itself does not claim either.' Care as an orientation or as a perspective is directed at living good in concrete relationships with others, responding to their needs and building up a joint life. It thereby underscores the importance of connection and attachment. What we need to do is to examine the results of theorizing *from the lens* of this care orientation and see what emerges about the claims of 'strangers' and of 'intimates' (Little, 1998, p. 204). And so it remains to be seen what kind of proposals care ethics theoretically leads us to. Some care ethicists have pointed to the importance of trust and self-trust in moral life (Baier, 1995; Govier, 1992). Loyalty, friendship and caring as important moral concepts seem to be neglected or marginalized in the ethical discourses so far. Other concepts, such as respect, receive a different meaning in the care perspective. For instance, Robin Dillon has developed a care perspective on the notion of respect, in which respecting a person involves valuing and treating her not as a case of generic personhood but as the whole and concretely particular person she is (Dillon, 1992). Interestingly enough, she thereby sees the core element of care as a form of attention and moral appreciation of individual persons. "The term 'care' denotes here an epistemic attitude , understood as a moral ideal of attention: a commitment to attend, with intensely focused perception to all aspects of the irreducible particularity of individual human persons in their concrete contexts" (Dillon, 1992, p. 128). In that way, care ethics promotes a particularistic moral epistemology in which attention, contextual and narrative appreciation, and communication are considered as elements of moral deliberation.

In this article I want to concentrate on what care ethics as a moral orientation implies for the concept of autonomy. With the introduction of a relational account of moral agency and the idea of interdependency as characteristic of human existence, care ethics introduces a concept of autonomy which has so far been marginalized in moral theory.

A care critique on autonomy

Some have misunderstood the care perspective as if it would have no place for a concept of autonomy. Now it is certainly true that there is some tension between care and autonomy. For instance, traditional practices of care in which care was seen as solely a 'women's practice' have undermined the personal autonomy of women themselves. For a long time women have been socialised to curb their ambitions and to identify themselves with the goals of others to the neglect of their own. Connecting this with the fact that care in terms of caring work is very much socially devalued in society, only worsens women's situation. It is because of these reasons that Joan Tronto argues that an ethics of care remains incomplete without a political theory of care. That is, care is only viable as an ideal in the context of liberal, pluralistic and democratic institutions. For reasons of space I shall not elaborate further on the political implications of an ethics of care.

Whereas care ethics has been criticized for not sufficiently safeguarding the personal autonomy of carers, care ethics itself contains a fundamental critique on autonomy. This care critique on autonomy is focused on the idea of a self as free and independent. In order to understand this critique on autonomy properly, a distinction must be made between an ideal of autonomy in terms of self-sufficiency and independency on the one hand, and autonomy in terms of the moral capacity to make one's own choices in life on the other hand. It is precisely this ideal of self-sufficiency that is fiercely criticized by care ethicist's. The ideal of self-sufficiency rests on the idea that a good life is a life in which we do not need the help or support from anyone in meeting our needs and carrying out our life plan. This idea of the self as 'disembedded and disembodied' has played a prominent role in moral and political theory. Not only care ethics, but also communitarian perspectives have criticised this conception of the self and have criticised it as abstract, empty and unrealizable. But care ethicists differ from these other criticisms in the way that care ethics points to the effects which the dominance of independence as an ideal has for the moral status of persons. In feminist literature, but also in the literature on disability, it is stressed that the value of independence has adverse consequences for women and disabled persons. Dependence on the help of others is often humiliating in a society which prizes independence. Susan Wendell therefore pleads for the ideal of interdependence (Wendell, 1996). She states that we should question our cultural obsession with independence and replace it with a model of reciprocity. If the disabled are to be fully integrated into society without symbolizing failure, then we have to change social values to recognize the value of depending on others and being depended upon.

To understand the value of care itself, it is therefore necessary that we rethink the human condition as interdependent. It is also because of this that Tronto defines care as a species activity and as an ongoing practice that is aimed at maintaining, continuing and repairing our world.

In starting from the assumption of human interdependency, care ethics points our attention to other moral issues and questions. For instance, it is more concerned about the dangers of abandonment than the dangers of interference. It sees moral questions more in terms of responsibilities than of rights. This is not to say that care ethics is simply not interested in rights, equality or autonomy, but it does try to develop alternative conceptions of these terms. The critique of autonomy in terms of self-sufficiency still leaves room for an idea of autonomy as the moral capacity to make one's own choices in life, sustained by others. More precisely, care ethics leaves room for a conception of autonomy which is not defined in opposition to relations of dependence and connection. Diana Meyers, for instance, suggests that we should think about autonomy as a competency which in its turn is defined as a repertory of co-ordinated skills that enables a person to perform a specified task (Meyers, 1987). These skills are used in concert in order to carry out a procedure which allows one to monitor one's conduct and determine whether or not it is in accordance with one's true self. An autonomous agent asks questions such as 'Can I take responsibility for this or that action while retaining my self-respect?' or 'Could I bear to be the sort of person who can do that?' The true self that is consulted in this process is not to be understood as a true self in ontological terms, as a self that can be discovered by stripping back the layers of socialisation. Instead, the true self is dynamic, it is – as Meyers puts it – an evolving collocation of traits that emerges through the use of autonomous competency (Meyers, 1987, p. 76). The true self is an 'encumbered self', a self that is always already embedded in relationships with flesh and blood, others and is partly constituted by these relationships. By developing a relational concept of moral agency, care ethicist's lay stress on the necessity of having relationships in order to see oneself as autonomous.

So far, the care critique of autonomy can be summarized as follows. In the first place, it questions the idea of self-sufficiency and independence as the main value for human living. It points to the fact that in emphasizing this ideal of independency other values such as trust, caring and responsibility are neglected in the moral discourse. Secondly, autonomy as a moral competency is not to be seen in isola-

tion from other persons and relationships. Instead, it stresses that autonomy as a moral capacity can only be developed in relation to others. It is important to underscore the insight that this critique of autonomy does not imply a rejection of the notion of autonomy altogether. The care perspective leaves room for autonomy, as an idea of moral competency, which in turn is reconceptualized as defined to relationships. In their book *Relational Autonomy – Feminist Perspectives on Autonomy, Agency and the Social Self* (2000), Catriona Mackenzie and Natalie Stoljar divide relational conceptions of autonomy into constitutively relational conceptions and causally relational conceptions (Mackenzie and Stoljar, 2000, p. 22). Those approaches focusing on the social constitution of the agent or the social nature of the capacity of autonomy itself, are *constitutive* conceptions, whereas those focusing on the ways in which socialization and social relationships impede or enhance autonomy are *causal* conceptions. The constitutive approach sees the self as relational in the sense that one of the fundamental ways a person conceives of himself and thinks about the world around him is in terms of the relationships in which he is involved (Keller, 1997). The causal approach underwrites the view that the capacity for autonomy is the product of the appropriate kind of social training and of social and historical contexts. For instance, Diana Meyers (1987) analyses in her work the ways in which oppressive social environments can impair agents' autonomy on a causal level (Mackenzie and Stoljar, 2000, p. 22). In a concept of relational autonomy both dimensions should play a role. In the following I shall concentrate on the meaning of relational autonomy as moral competency and try to show how relationships – constitutively and causally – can be of importance in developing autonomy. I shall elaborate on the notion of relational autonomy by making use of the discussion on introducing more-or-less interfering interventions in social psychiatric care.

Compassionate interference and attaining autonomy

I think that the alternative conception of autonomy, known as 'relational autonomy', can have merit in the discussion of some moral issues that we face today. I wish to show this by briefly examining one example. In the Netherlands, there is a growing debate over involuntarly institutionalisation and other compulsory treatment of mental patients. In 1994, a law on Involuntary Admittance to Psychiatric Hospitals (Wet Bopz) was passed. This law determines the legal position of the psychiatric patient who face possible coercive institutionalisation. In contrast to the past, coercive institutionalisation and compulsory treatment are no longer justified for paternalistic reasons. The right of self-determination overrules considerations of protecting the well-being of patients. Only in cases of severe risk and danger to society and patient are coercive interventions legally and morally justified. Particularly in the context of psychiatric health care, however, the dominance of respecting the right of self-determination is being questioned. In fact, in 1997 the Dutch government asked the National Council of Care as to advice, whether coercive interventions for reasons of protecting the well-being of patients could not be justified under certain circumstances. By posing this question, the government started a re-evaluation of the Wet Bopz. This re-evaluation is the more pressing if we consider certain recent developments in health-care policies. In the Netherlands, a process of de-institutionalisation has been taking place. More and more patients with chronic diseases remain outside the institutionalised forms of care. This means that care is becoming more socially integrated and the patient more emancipated. This process of de-institutionalisation has as its side-effect that patients sometimes do not receive the care they need. This especially applies to those patients who have developed a deep distrust towards the care system and because of that, avoid care.

In reaction to this situation, practitioners in social psychiatric care have pleaded for the introduction of what they call 'compassionate interference' in caring relationships. By making this particular plea, practitioners are stressing the need for a different outlook on what good care should mean. Instead of taking an attitude of non-intereference and thereby respecting the autonomy of the patient, there was a plea for an active and committed role for the professional care taker. The carer should not stand aside. On the contrary, he should follow the patients, look him up, and direct him when necessary. This professional attitude aroused a lot of hostile reactions of which the most often heard was that of 'modern paternalism'. 'Compassionate interference' does not appear to be the politically correct answer in caring relationships today. Respect for autonomy even seems to exclude a professional attitude of attentiveness and commitment. However, the practitioners have pointed out that the current concept of care leaves us with a paradox. Current practices of care conceive patients as individuals who have a strong interest in freedom and non-interference, whereas at the same time a lot of patients have a desperate need for flourishing and viable relationships. In fact, part of their problem is that they cannot relate very well with other people.

I think that a care perspective can offer us arguments for 'compassionate interference' without thereby being trapped in a balancing strategy between a respect for self-determination and paternalism. In the first place, I have described the care perspective as a perspective in which there is more concern about the dangers of abandonment than about the dangers of interference. This should direct our attention to how people can relate to each other, rather than how they can be left free. The critique of the practitioners can be understood as a critique of a care vision in which the ideal of autonomy as self-sufficiency and independency is dominant. Instead they plead for a care perspective in which having relationships and commitment is important. In this they also stress the idea of conceiving the person as having a relational identity. Secondly, the moral question in a care perspective is presented in terms of responsibilities rather than of rights. The idea of a good care relationship is not captured in terms of a right for non-interference on the part of the one being cared for and a duty not to interfere on the part of the carer. Instead, the relationship is seen as a relationship in which responsibilities towards each other are set. In that perspective, compassionate interference as a treatment can be conceived as a form of a caring relationship in which the responsibilities of the carer as well as of the care-receiver are put at the forefront. The carer has a responsibility to be attentive to the needs of the care-receiver whereas the care-receiver is asked to be responsive to the care given. In this perspective on care, the emphasis is on care as a process. Finally, in developing a more relational model of autonomy, interventions in care can be shown to be in the interest of patients, that is, they can be seen as interventions for attaining autonomy, instead of threatening autonomy. In a conception of relational autonomy socialization, social relationships can impede as well as improve autonomy as a moral competency. In particular, patients in social psychiatric care experience impediments in their attaining autonomy. For instance, they sometimes experience a low level of self-respect and self-esteem which are themselves the result of certain types of oppressive and damaging social experiences. A reduced self-respect undermines autonomy by undermining the individual's sense of himself as capable of making judgments. Moreover, as the messages of reduced self-respect are internalized, these impediments are not easily removed. Instead, those patients should be helped in caring and committed relationships to regain their self-esteem. 'Compassionate interference' is described by patients themselves as 'committed care', 'as being there', as 'standing next to me'. It is seen as a form of care in which the carer sees the patient as someone of importance, as someone who is worthwhile standing next to. In this respect compassionate interference can be seen as a form of care in which the patient has an opportunity to become autonomous. Although more needs to be said in order to give a concrete moral justification for compassionate interference, I think that the above considerations show that a care perspective can handle questions of compassionate interference and other so-called compulsory treatments more fruitfully (see also Verkerk, 1999).

Conclusion

In this article I have tried to make clear how a notion of individual autonomy can have a place in care ethics. From a care perspective, autonomy is criticized on two grounds: First, the ideal of autonomy in terms of independence and self-sufficiency is criticized. Instead an idea of interdependency, descriptively and prescriptively, is emphasized. Secondly, autonomy as moral competency should get rid of its individualistic connotations. Instead a notion of relational agency should be introduced as underlying the concept of autonomy. By way of an example I have tried to show how a care perspective on autonomy can have merit for actual discussions in social psychiatric care.

Note

1. In a recent article in the *Journal of Medicine and Philosophy* (1998), Robert Veatch asks himself this very same question: What kind of ethical theory is care ethics? For Veatch the question of what kind of ethical theory care ethics is, remains obsolete.

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