

Reply to Ann Bradshaw

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Abstract

My original paper suggested that an ethics of care which failed to specify how, and about what, to care would be devoid of normative and descriptive content.

Bradshaw's approach provides such a specification and is, therefore, not devoid of such content. However, as all ethical approaches suggest something about the 'what' and 'how' of care, they are all 'ethics of care' in this broader sense. This reinforces rather than undermines my original conclusion. Furthermore, Bradshaw's 'ethics of care' has philosophical and historical problems which I outline.

Introduction: an ethics of care?

I should like to thank Ann Bradshaw for addressing herself to me in her article (1), which was far more wideranging than my own (2). Indeed she seems to have used my article as a springboard to wider issues but not really to have any substantive disagreement with me except, perhaps, over points on which I should have been clearer.

In particular, I did not mean to suggest that 'care' was nothing more than 'self-concern' (3), nor that it was devoid of moral import (4). It is clear that care and its cognates are very commonly used as terms of moral approval and approbation, as when we call people and actions caring, careless and uncaring.

What I did suggest was that such judgments are not based upon the absence or presence of care in itself. We do not deem someone to be caring simply because they care for or about something or someone. A caring person cares for the right things in the right way. It follows that any ethics which emphasises care itself, enjoining us to be caring or to do the caring thing will be devoid of content. I believe this to be a fault in much of the caring ethics literature.

Bradshaw, in her comments on Noddings (5), seems to agree (6). Bradshaw suggests that caring conveys moral meaning because it is attached to a (religious) tradition which gives it meaning and

forms its basis. Thus a caring person is one who embodies this tradition of universal love and altruism, not one who cares *per se*.

An ethics of care which specifies what to care about and how to express that care will *not* be devoid of content. Bradshaw appears to do this and, as such, may be said to have specified a meaningful ethics of care. However, on this basis virtually all other ethical systems are also ethics of care. Utilitarianism, Kantianism, Principlism, even Nietzsche, all have something to say about the 'what' and 'how' of care.

'Can there be an ethics of care?' The answer remains 'No' if the focus is on the bare fact of care itself. The answer is 'Yes' if something is specified about the 'what' and 'how' of care. But, as all ethical systems appear to do this, 'ethics of care' will do little more here than specify the genus 'ethical theory'. Narrowly defined, the ethics of care is contentless; broadly defined, it is non-specific.

This was the chief focus of my paper. Bradshaw seems to have little substantive disagreement with it, nor does she say anything to undermine my conclusion. I would, however, like to comment on the rest of her interesting paper.

Bradshaw's ethics of care

Bradshaw's argument bears comparison with that of MacIntyre in *After Virtue* (7). He suggests that the reason moral debate has become intractable in the modern world is because moral terms (such as 'good', 'just', and 'unfair') have become detached from the teleological scheme which gave them meaning in earlier times. Greek and Judaeo-Christian philosophy gave meaning by reference to a *telos* or endpoint for humanity. This *telos* might be related to social role, such that 'right' would mean 'right for someone in my station', or to a religious purpose such that 'right' might mean 'obeys biblical law and prepares the world for the Messiah', or to man's nature such that 'right' means 'fulfils man's "ergon"' or 'function'.

MacIntyre suggests that, since the Enlightenment, we have lost the idea of such a *telos*. We have tried to give meaning to ethical terms by the use of pure

Key words

Care; caring ethics.

reason. But reason cannot do this. It is rather like trying to obey the imperative 'travel' without ever asking 'where?' Given conflicting views about morality we have no rational way to choose (8).

Bradshaw suggests that caring in its moral sense has its base (*telos*) in Judaeo-Christian tradition. This is expressed in the work of Buber (9). Buber's work is difficult and rather pleonastic. It seems to say that God is present when we confront others and so we are enjoined by God to love all others; in loving them we love Him (10).

Bradshaw claims that this tradition of altruism and universal love has had a profound influence on nursing and medicine. She also suggests that the loss of this tradition causes (inter-linked) theoretical and practical problems. On the theoretical side she cites two writers who have 'lost' the tradition. First, Kant, whose attempt to found ethics in the realm of pure reason meant that caring became subsumed in the duty of the categorical imperative. Second, Noddings, whose attempt to found ethics in the realm of pure emotion meant that caring became uncontrolled and indiscriminate.

Bradshaw and I agree on the problems with Noddings. With Kant, Bradshaw suggests, the problem is the 'coldness' (11) of his approach. She is also aware of the huge technical problems in Kant (12). This awareness is reflected in her suggestion that without Judaeo-Christian grounding, *pace* Kant, we have no reason to care for others. Like MacIntyre (13) she seems to suggest that without a teleological basis only Nietzsche's ethics is credible (14).

The effect on practice is that without a moral reason to care what possible reason is there to give health care? Whilst the obvious answer is, 'in order to make a living', this provides no reason why we should offer health care to those unable to pay.

So, without caring in the Judaeo-Christian sense, we are left without reason to care for others, indeed without reason to be moral at all. What are we to make of this? I believe that there are both historical and philosophical problems with Bradshaw's account.

Historical problems

Whilst there is little doubt that Judaeo-Christian beliefs have had a profound influence on medicine and nursing (as elsewhere in society), the idea that developments in this realm were 'underpinned' (15) by altruism and universal love is not credible. Much health care was inspired by the desire to get a population fit to fight or to produce. Marx (16) shows how some reforms were due to anger and class struggle. Some medical developments were probably more the result of abstract scientific curiosity than of altruism. Religious beliefs and motivation may have provided one 'fuel' in medicine and nursing, but by no means was this the only one.

It is also possible to doubt whether health care which *was* fuelled by religious beliefs has always been warm and well-directed. One thinks of the gross paternalism characteristic of much health care until recently, of the atrocious treatment of the insane, and of research projects which, whilst motivated by a desire to care for the population, abused and exploited the vulnerable (17). Bradshaw might have to face the irony that, at a time when she suggests we are losing the moral basis of our care, the ethical standards of health care seem to be rising (18).

Philosophical problems

It seems that Bradshaw has replaced one slippery concept ('Care') with others just as slippery ('Universal love', 'Altruism' and 'God' or 'Thou'). For example, the existence or not of God is largely an irrelevance when it comes to the content of morality. Three examples are suggestive of this.

(i) There are occasions when schizophrenic killers claim that they have been following the word of God. Christians have no difficulty in denying that this is the case because God would not command us to do wrong. This means that 'right' means something other than that which God commands; the standard is independent of God. Similarly for other moral terms (19).

(ii) Millican (20) points to a section of the Old Testament (Deuteronomy 20:16–17) which appears to command genocide. Most Christians and Jews would seek to suggest that this is a mistranslation, or misinterpretation, or biblical aberrance, simply because they know genocide to be wrong.

(iii) Religious edicts require interpretation. The commandment not to kill has been widely interpreted as not to murder. As 'murder' means 'wrongfully to kill' it is still up to us to decide when killing is, and is not, wrongful (hence the debate about euthanasia).

What this suggests is that God cannot be the anchor for moral terms such as 'right', 'wrong', and 'caring'. Religious writings may appear to require universal love and altruism from us, but it is still up to us to decide whether or not this is reasonable.

Furthermore, it is possible to doubt whether an ethics which tells us to be altruistic or loving is offering us very much. Faced with someone in a persistent vegetative state, or with a handicapped fetus, or with a shortage of resources, to what does such an edict amount? And in that it amounts to anything, is it reasonable? Noddings is surely correct in suggesting that one cannot love everyone (21). I would go further and suggest that it may be wrong to require us to love those who are evil. Within my own nursing experience I have been required to look after people whom I genuinely believe to be bad. To have loved them in any meaningful way would have been morally reprehensible (22).

Conclusion

These are the historical and philosophical problems I perceive in Bradshaw's account. They are compounded by what seems an over-romantic view of nursing as some sort of saintly vocation. As Lucas puts it:

'Nursing is neither a profession nor a vocation; it is neither a science nor an art. Nursing is a job of work, the limits of which are defined largely by medicine, which at its best is carried out with competence, displays respect for persons, and aims to achieve the best possible level of health' (23).

Nursing is a disparate job performed by individuals with differing motives and beliefs. Whilst I believe it helps to be a 'caring' person (24) it seems clear that a religious attitude of universal love and altruism is unnecessary, does not underpin medicine and nursing, is unreasonable to ask of health carers, and may even be morally wrong (25).

Acknowledgement

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References and notes

- (1) Bradshaw A. Yes! There is an ethics of care: an answer for Peter Allmark. *Journal of medical ethics* 1996; 22: 8–12.
- (2) Allmark P. Can there be an ethics of care? *Journal of medical ethics* 1995; 21: 19–24.
- (3) See reference (1): 9.
- (4) See reference (1): 8.
- (5) Noddings N. *Caring: a feminine approach to ethics and moral education*. Berkeley: University of California Press, 1984.
- (6) See reference (1): 9–10.
- (7) MacIntyre A. *After virtue* [2nd ed]. London: Duckworth, 1985.
- (8) MacIntyre goes on to suggest ways of restoring teleology through the idea of a 'practice' and to explore the idea of rationality within a tradition. (See also MacIntyre A. *Whose justice? Which rationality?* London: Duckworth, 1988.
- (9) Buber M. *I and thou* [trans Kaufmann W]. Edinburgh: T and T Clark, 1970.
- (10) I cannot say that I fully understand Buber, nor the interpretations of him. I suspect that faith is required before understanding occurs. The importance of faith in the understanding of such things is suggested by A A Milne in *Now we are six*. London: Magnet, 1987: 80; a child asks her doll a question about God, the doll squeaks in reply: 'What did it mean? Well to be quite candid, I don't know but Elizabeth-Anne did'.
- (11) See reference (1): 10–11.
- (12) For example, see Williams B. *Ethics and the limits of philosophy*. London: Fontana, 1985: ch 4.
- (13) See reference (7): ch 18.
- (14) Given Bradshaw's criticism of Kant and Noddings, it is surprising to see her suggest (on page 11) that her ethics of care could provide a bridge between them. Why should one want to reach a compromise between two wrongs? However, I'm not sure of the significance of her use of the term 'attitudes' rather than 'theories' at this point.
- (15) See reference (1): 8.
- (16) Marx K. *Capital vol I* [trans Fowkes B]. Harmondsworth: Penguin, 1976: ch 10.
- (17) Examples of well-meant wrong-doings are provided in many texts, for instance in Beauchamp T, Childress J. *Principles of biomedical ethics* [3rd ed]. New York: Oxford University Press, 1989.
- (18) The very fact that we see problems with, for example, paternalism where previously we did not, is indicative of this.
- (19) This argument is well known and has been around a long time; for example Plato. *Euthyphro*. Oxford: Clarendon, 1909: 7a 2–8 b6.
- (20) Millican P. The complex problem of abortion. In: Bromham D, Dalton M, Jackson J, Millican P, eds. *Ethics in reproductive medicine*. London: Springer-Verlag, 1992: 161–188.
- (21) See reference (5): ch 1.
- (22) '... care may not be morally good when felt towards a person known to be thoroughly evil, and likewise, hatred and resentment of such a person may here not be morally bad.' Oakley J. *Morality and the emotions*. London: Routledge, 1992: 40.
- (23) Lucas J. The nature of nursing. *Health care analysis* 1993; 1, 1: 24.
- (24) For an interesting discussion on this related to surgeons see Cassell J. The good surgeon. *International journal of moral and social studies* 1987; 2: 155–171.
- (25) This, of course, still leaves us with the question which my original paper only partially addressed, and which Bradshaw has addressed but with whom I have disagreed. That is, when we use the term 'caring' to convey moral approval, what do we mean? As I said earlier, all ethical theories will offer answers of varying content and complexity to this question. To outline a favoured reply is beyond the scope of this article.