AGAINST THE STREAM:
WHY NURSES SHOULD SAY “NO”
TO A FEMALE ETHICS OF CARE

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Do women and men approach ethics differently? In his book *Emile*, Jean-Jacques Rousseau gave an affirmative answer:

A woman’s reason is practical, and therefore she soon arrives at a given conclusion, but she fails to discover it for herself... [The man teaches the woman what to see, while she teaches him what to do... If women could discover principles and if men had as good heads for detail, they could be mutually independent... The search for abstract and speculative truth, for principles and axioms of science, for all that tends to wide generalisation, is beyond a woman’s grasp; their studies should be thoroughly practical. It is their business to apply the principles discovered by men, it is their place to make the observations which lead men to discover those principles... Women should discover, so to speak, an experimental morality, men should reduce it to a system... woman observes, man reasons (1).

In this passage, Rousseau is suggesting a number of things, among them the following:

Firstly, that women and men approach ethics differently. Women have a fine eye for detail, and their reason is practical. They are incapable of systematizing their observations, and of developing abstract general principles of conduct. It is up to men to assemble this “experimental” female approach to ethics into a coherent and principled whole.

Secondly, that the male and female approaches to ethics are complementary, that is, that one cannot stand without the other.

Thirdly, that the principled male approach to ethics is somehow superior to that of women and that it is the business of women “to apply the principles discovered by men”.

Mary Wollstonecraft, a contemporary of Rousseau’s, was among the first of a long line of women who were angered by the view of women that underpins Rousseau’s writings (2). Nonetheless, there is a school of thought among feminists today which accepts that Rousseau was right on at least one point: that women and men do approach ethics differently. This school of thought does not merely deny that women are incapable of abstract ethical thought; rather, it makes the much more fundamental claim that it is a mistake to assume that the abstract, principled “male” approach to ethics is the authoritative one, to be applied universally by both women and men. There is an alternative “female” approach to ethics, these feminists suggest, which is based not on abstract ethical principles or wide generalisations, but on practical reasoning in particular situations, where the agent responds from the vantage point of relatedness, receptivity and responsiveness to the needs of “concrete” others. Such an ethics, somewhat akin to the “experimental morality” Rousseau seems to have had in mind, has come to be known as a (female) “ethics of care”.

II.

Until fairly recently, nursing and feminism have had little to do with each other (3). Given that almost all nurses are women, this is perhaps somewhat surprising, but the reasons shall not occupy us here. What is important to note is that nurses have, over the past decade, taken an increasing interest in feminism — that kind of feminism which holds that women and men do approach ethics differently. Keen to distinguish themselves from the male-dominated

profession of medicine and male doctors, nurses have begun to look towards a “female ethics of care”, in the belief that this might provide them with a theoretical basis for establishing their separate identity as women and nurses.

Such a basis seemed to become available in 1982, when Carol Gilligan published her highly influential book: In a Different Voice (4). In this book, Gilligan claimed that she had obtained empirical evidence which demonstrated that women and men do approach ethics differently, and that there are different male and female paths to moral maturity. She challenged the contention of the well-known Harvard psychologist, Lawrence Kohlberg, that women’s moral development is somewhat deficient when compared with that of men. On the basis of an all-male study, Kohlberg had devised a six-stage scale of moral development, where abstract principles of justice occupied the top level, whilst concern with helping and caring for others were ranked only as the third stage. Gilligan charged that Kohlberg’s very measure of moral development had a male bias. It marked as deficient, Gilligan held, women’s care for, and sensitivity to, the needs of others — “the very traits that have traditionally defined the ‘goodness’ of women” (5). Distinguishing between an ethics of care and an ethics of justice (6), Gilligan thus challenged a long tradition which assumed that there is but one ethics, and but one path to moral development.

If Gilligan’s theory of separate male and female moral development seemed to provide nurses with an empirical basis upon which to build their separate identity (7), it was Nel Noddings’ book — Caring

(6) Gilligan does not claim that all men approach ethics from a justice perspective, and all women from a care perspective. Right at the beginning of her book, she writes: “The different voice I describe is characterized not by gender but theme... The contrasts between male and female voices are presented here to highlight a distinction between two modes of thought and to focus a problem of interpretation rather than to represent a generalization about either sex.” (Carol Gilligan: In a Different Voice, op. cit., p. 2.)
(7) Carol Gilligan’s studies have been strongly criticized as being unsystematic and unscientific. See, for example, James R. Rest: Moral Development: Advances in Research and Theory, New York: Praeger, 1986. For an extensive discussion of the many vexing issues raised by Carol Gilligan’s thesis, see the collection of essays in Eva Feder Kittay and Diana T. Meyers (eds.): Women and Moral Theory, Totowa, NJ: Rowman and Littlefield, 1987.
- *A Feminine Approach to Ethics and Moral Education* (8) — which, many nurses thought, could provide them with an appropriate ethical foundation. In this book, Nel Noddings develops what she calls a “feminine ethics” — an approach “rooted in receptivity, relatedness, and responsiveness” (9). This “approach of the mother” is contrasted with the principled and universal “approach of the father”. She suggests that a principled male ethics is not only at odds with women’s moral thinking, but also somewhat defective and inadequate in itself because universal principles have no role (or at best a very limited role) to play in ethics (10).

Numerous nursing theories are based on concepts of caring and relatedness (11). Indeed, as Sarah Fry, a prominent writer in the field, has put it, there is a connection between “the type of functions that are usually associated with the practice of nursing” and the value of caring and feminism (12). This means that we should perhaps not be too surprised to find that nurses, who had remained largely untouched by earlier feminist thinking, should so eagerly welcome a “female ethics of care”.

Few dissenting voices can be heard (13), and the ranks of those ready to embrace a nursing ethics of care seem to be steadily growing. Despite the fact, however, that an “ethics of care” has so

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(9) The “feminine approach” is, Noddings suggests, also open to men. While it may be the case that it is more typical of women than of men, this is an empirical question she does not attempt to answer. (Nel Noddings: *Caring*, *op. cit.*, p. 2.)

(10) Nel Noddings: *Caring*, *op. cit.*, pp. 1, 2, 5, 84-85.


captured the moral imagination of nurses, I believe there are good reasons why nurses should reject it with a firm “no”.

III

It is often thought that if only people cared enough, many of our problems would be solved — not only in the health-care context, but in the world in general. As the Assistant Federal Secretary of the Australian Nursing Federation recently put it in an address to nurses:

Isn’t it time we examined our attitudes to the caring role? Have we bought the patriarchy’s evaluation of it, or do we believe it is the basis for the planet’s survival? Shouldn’t we make every effort to keep the carers caring? We can do that by inverting patriarchal values which encourage nurses to leave the profession to seek more “meaningful” and “rewarding” work such as the law, medicine, real estate, entrepreneurial nursing services and managing hotels (14).

The idea that there are certain female virtues which might save the world, or at least make it a better place, is not new. It was also at the heart of Rousseau’s conception of the role of women. However, whereas Rousseau thought that women would lose their special moral virtues once they became independent and ventured beyond the private sphere of the family, it is a continuing strand of feminist thought that women, far from being corrupted by the world, would make the harsh male-dominated world a better place by bringing some of the traditional female virtues to bear on it. Almost a century and a half ago, the US suffragist Elizabeth Cady Stanton spoke of the “male element” as a destructive and selfish force, which loved war, acquisition, violence, conquest and so on, “breeding in the material and moral world alike discord, disorder, disease and death”. What was needed, Stanton said, was “a new avengel of womanhood, to exalt purity, virtue, morality, true religion, to lift man up to the higher realms of thought and action…” (15)

In less effusive (but not necessarily less colourful) language, many feminists today still give expression to their belief that a “female ethics” is needed to save the world from the consequences of human activities that have their basis in a male value system, based on domination, conquest and aggression on the one hand, and on men’s adherence to abstract and rigid moral principles on the other. Adapting a statement by Virginia Woolf, Helen Bequaert-Holmes thus tells us that medicine “is not sexless; she is a man [sic], a father, and infected too”, and that some feminists philosophers “feel called to be healers” (16); and Nel Noddings in her previously cited book Caring reminds us that today’s world is “wracked by fighting, killing, vandalism, and psychic pain of all sorts”. What is particularly saddening about this, Noddings continues, is “that these deeds are so often done in the name of principle” (17).

What is common to many of these writers is the belief that a new “female ethics” based on “care” rather than on “male principle” will be able to help us solve many of today’s ills, including those that bedevil health care, where, the nurse theorist Jean Watson points out, “the medical ethic of rational principle, fairness, and equity” will be counteracted by “the ideals of human caring”. Quoting Noddings, Watson continues, an ethics of care “ties us to the people we serve and not to the rules through which we serve them” (18).

I am deeply sympathetic (who wouldn’t be?) to the enterprise that seeks to replace fighting, killing, vandalism, the exploitation of women and nurses, of non-human animals and the environment, by a more benign or caring approach. I do, however, believe that it is a mistake to assume that this can be achieved by replacing universal ethical principles with an ill-conceived “ethics of care”. The reasons, I hope my subsequent discussion will make clear, have to do with a confusion, in the notion of care, between morally relevant disposi-

tions and principles for action, and a mistaken view of the role of principles in moral thinking.

“Care” is a rich and highly ambiguous notion, and it is not always clear what we mean when we speak of “care” and of “caring” in our relationship with other people, animals, the environment, books, personal computers, our cars, or the dozen lettuce plants we have just transplanted to our vegetable patch. Caring for another person — the notion that will occupy us in the present context — has connotations of concern, compassion, worry, anxiety, and of burden; there are also connotations of inclinations, fondness and affection; connotations of carefulness, that is, of attention to detail, of responding sensitively to the situation of the other; and there are connotations of looking after, or providing for, the other (19).

Some of the connotations of “care” have a link to behaviour or action — for example, “responding sensitively to” or “providing for” a person; other connotations, such as “feeling anxiety” or “feeling affection”, are not directly action linked — although they will often motivate a person to do something that will alleviate her anxiety or express her affection.

There is not only the dichotomy between affective feelings and actions, the various strands of the notion of “care” may also pull in different directions. To give just two examples: A nurse may care for a patient (in the sense of looking after his health-care needs) without caring for him (in the sense of liking him, or being fond of him); or a nurse may care for a patient in the sense of being fond of him, but fail adequately to care for his health-care needs. Similarly when it comes to morally disputed decisions: a nurse who allows a severely handicapped infant to die may be charged, by one person, with being uncaring, while being praised, by another, for having acted with great care and compassion.

It has thus been pointed out in the literature that nurses use the term “care” as a slogan, or as a vague and ambiguous term, without much thought about its different meaning in different nursing contexts (20). Madeleine Leiniger, who has herself written much about

(19) On the richness of the notion of “caring”, see Nel Noddings: Caring, op. cit., pp. 9-16.
"caring", is ready to admit that even though nurses are "the professional group who repeatedly use the expression 'nursing care', 'care' and 'caring' in everyday parlance, the linguistic, semantic, and professional usages of these terms are still limitedly understood and studied (21). While the ambiguous usage of a word may be tolerable in everyday nursing life, it is clear that it will not do for the purposes of explicating and defending a nursing ethics of care. If "care" is to function as the central concept of an "ethics of care", we need to be clear about its meaning and its normative implications.

An excursion into the professional nursing literature will, however, not be rewarded by great enlightenment. Nurse theorists speak about "care" in terms which are imprecise and obscure (sometimes even mystical), which many practising nurses, I have been told, find deeply enigmatic. What does the highly acclaimed nursing theorist, Sally Gadow, for example, mean when she says that

...care is an end in itself. While it may serve as a means of reaching a further state, it is always and above all a state that itself can be fully inhabited. While it may serve as a vessel for reaching a remote shore, it is at the same time and above all a vessel in which one can live even when — especially when — there is no destination in sight or in mind (22).

And what does Jean Watson, another prominent writer in the field, have in mind when she holds that true "transpersonal caring" entails that "the nurse is able to form a union with the other on a level that transcends the physical... [where] there is a freeing of both persons from their separation and isolation..."? (23). Other writers speak of "care" as "a feeling of dedication to the extent that it motivates and energizes action to influence life constructively and positively by


(22) Sally Gadow: "Covenant Without Cure: Letting Go and Holding on in Chronic Illness" in (eds.) Jean Watson and Marilyn Ray (eds.): The Ethics of Care and the Ethics of Cure..., op. cit.. pp 5-6.

increasing intimacy and mutual self-actualization” (24); an “interactive process”, which is achieved by a conscious and intuitive opening of self to another, by purposeful trusting and sharing energy, experiences, ideas, techniques and knowledge” (25); or as “the creative, intuitive or cognitive helping process for individuals and groups based upon philosophic, phenomenologic, and objective and subjective experiential feelings and acts of assisting others” (26).

Now, it may be unfair to quote these writers selectively, outside of the particular context in which they are writing, and to then accuse them of vagueness and obscurity. While this may be true with regard to some of the writers quoted here, it is not true of all of them. Nonetheless, a sympathetic reading of the dominant theories of “caring” reveals a number of common threads. There is concern with relationships, receptivity, responsiveness, and close attention to the details and nuances of particular situations. On these views, it is not only important what we do, but also, as the above quotations suggest, that we bring the right attitude or spirit to the situation. “Caring” is understood as “a state”, a “transpersonal” psychological ability, “a feeling of dedication, an “interactive process” and an “experiential feeling[s]”, that is, a psychological or existential state, or moral stance, towards patients. What is clear is that exponents of a “nursing ethics of care” are not putting forward an ethical theory of action, but rather attribute moral significance to psychological attitudes or states, which are characterized by an openness and willingness to share experiences, feelings of dedication, and the like. Nel Noddings’ understanding of “care” as “engrossment” (a putting aside of self, and receptivity and responsiveness to the experiences of others) seems to have a similar basis (27). To distinguish this understand of “care” from the practical notion of professional nursing care (that is, the nurse’s careful and skilled practical attention to the health-care needs

of the patient), I shall refer to notions of care which focus on broadly attitudinal features or moral dispositions as “attitudinal care”.

Now, one might want to criticize some notions of “dispositional care” as asking too much of nurses — by, for example, burdening them with a notion of caring that goes beyond professional commitment and which may well be outside the reach of most nurses. (Jean Watson’s requirement that in true “transpersonal caring... the nurse is able to form a union with the other person on a level that transcends the physical” (28) might be an example of this.) These criticisms have been made elsewhere (29), and I shall not repeat them here.

For the purposes of our discussion, let us set the problems connected with the attitudinal content of the notion of care aside. I take it as given that that there is some sense in which our attitudes or dispositions matter and that a caring disposition — perhaps best understood in Nel Noddings’ sense of sensitive openness to “the reality of the other” — will result in better patient care (30). It emphasizes the importance of moral attitudes or dispositions, as well as the uniqueness of particular persons and situations. Health-care professionals with such caring attitudes are more likely to recognize patients as particular others, that is, as individuals, with special needs, beliefs, desires and wants — rather than, say, as “the cancer” in Ward 4.

It may well be true, as Lawrence Blum has recently observed, that moral philosophy’s traditional preoccupation with action-guiding rules and principles, and focus on such notions as universalizability and impartiality, have masked the importance of what he calls “moral perception and particularity” — that is, the important role that is played by our ability to see moral situations for what they are; for all the moral principles in the world (and our willingness to employ them) will not help if we lack the kind of “moral perception” necessary to accurately perceive a moral situation (31). Blum illustrates his point with the following example:

(28) See note (23).
(30) Nel Noddings: Caring, op. cit.
Joan and John are sitting riding on a subway train. There are no empty seats and some people are standing; yet the subway car is not packed so tightly as to be uncomfortable for everyone. One of the passengers standing is a woman in her thirties holding two relatively full shopping bags. John is not particularly paying attention to the woman, but he is cognizant of her.

Joan, by contrast, is distinctly aware that the woman is uncomfortable. Thus different aspects of the situation are “salient” for John and Joan. That is, what is fully and explicitly present to John’s consciousness about the woman is that she is standing holding some bags; but what is in that sense salient for Joan is the woman’s discomfort. That an aspect of a situation is not salient for an agent does not mean she is entirely unaware of it. She could be aware of it in a less than fully explicit way.

Blum suggests that the difference between what is salient for John and for Joan is of moral significance. Joan, he says, perceives the woman’s good (i.e., her comfort) as at stake in a way in which John does not. This means that Joan perceives that a morally relevant value is at stake, which John does not see (32). It seems entirely plausible that “attitudinal care”, as I have roughly circumscribed the term, will aid a person’s moral perception: a nurse who is sensitively receptive and responsive to “the reality of a patient” is not only more likely than a nurse who lacks this disposition to be aware of the patient’s health-care needs, but also of the ethical questions that are raised in the clinical context.

IV

The last statement requires an important qualification, which will make the inadequacy of a caring attitude as basis for a “nursing ethics of care”, or indeed any other ethics, clear. To recognize a patient’s health-care needs, and to be able to adequately respond to them, the nurse needs formal and practical knowledge. Without such knowledge, she will not be able to recognize the many subtle signs that tell her about a patient’s health-care state, nor would she know how

to treat the patient, or indeed that treatment might be required. A parallel case can be made out for the nurse’s ability to recognize and respond to ethical issues. “Attitudinal care”, and moral receptivity in Blum’s sense, are indispensible preconditions for ethical thinking and an adequate response to them (33), but they cannot, by themselves, tell nurses what those ethical questions are. While it will sometimes be easy to recognize an ethically significant situation, where there is, for example, agreement about the ethical significance of the feature in question — as when a patient shows subtle signs of being in pain — there are many other situations where even the closest attention to “the reality of the other” cannot tell a nurse that a morally significant situation exists. The point is this: before we can recognize a morally significant situation, we must have some understanding of what we are looking for, or of what we ought to be attentive to. We need to have some understanding of the moral principles or values that are inherent in the situation and how they might be met or infringed. Just as a nurse cannot recognize or treat pain, if she does not know about pain, so a nurse cannot recognize and respond to an ethical value or principle unless she recognizes it for what it is — an ethical issue. To be able to do this, she needs some general principle of the kind: “unrelieved pain is bad”; “nurses have a moral and professional obligation to ensure that patients do not experience unnecessary pain”; or “always relieve pain, if you can”. Without such general principles, there will only be an array of brute facts, and no criterion as to how they should be ordered. This means that it is a mistake to think that a “female ethics of care” can be differentiated from a “male ethics of justice” by appeal to the distinction between a “principled male approach” and a “non-principled female approach”. Any ethics that is to be of any use in practice needs principles, as well as care.

The following not uncommon example will illustrate the point. Nurse N. believes it is wrong to keep alive an elderly patient, Mr. Smith, suffering from advanced Alzheimer’s disease; Nurse M. disagrees. How might such disagreement be resolved? Both nurses have looked after Mr. Smith for a long time, during rotating shifts, and both are “attitudinal carers” — receptive, sensitive and responsive to

(33) Some would want to say that they are an integral part of ethical thinking, but this is a question I shall not pursue here. Both approaches would have to find a satisfactory answer to the issue of action, which is the focus of my critique.
Mr. N’s needs. Doctor O., aware of the nurses’ close involvement with the patient, has asked them whether he should treat Mr. Smith’s pneumonia with antibiotics, or whether they would think it better if he left a door open for what is often called “the old man’s friend”. Nurse N. advises non-treatment, Nurse M. advises treatment. How is this disagreement to be resolved?

Both nurses recognize that they are faced by a moral question, not merely a medical one. Both want to do the best by Mr. Smith, and antibiotics, they again agree, would significantly enhance Mr. Smith’s chances of survival. Despite their agreement on the facts of the situation, they do, however, disagree about the course of action that ought, morally, to be taken.

In such situations it is frequently assumed that a “full narrative”, rather than the bare-boned dilemma that I have sketched, will provide the answer. Indeed, bare-boned dilemmas are often criticized by those writing in the care-tradition as hopelessly “abstract” and “too thin” to allow proper ethical judgment.

Nel Nodding thus provides a critique of abstraction by distinguishing the “approach of the father” from that “of the mother”:

The first moves immediately to abstraction where... thinking can take place clearly and logically in isolation from the complicating factors of particular persons, places, and circumstances; the second moves to concretization where... feelings can be modified by the introduction of facts, the feelings of others, and personal histories (34).

Noddings is correct when she suggests that additional facts, feelings, and personal histories often will, and ought to, make a difference to the our moral evaluation of the situation. Nurse M. might thus argue that the fact that Mr. Smith indicated in a “Living Will” that he did not want to be kept alive should he ever become “a vegetable”, is a morally significant factor which ought to swing the scales in favour of non-treatment. But two points need to be noted here. Firstly, that Nurse M., in her appeal to Mr. Smith’s previously expressed wish, is appealing to a moral principle of the sort: “If someone says that he doesn’t want to be kept alive under certain circumstances, then this is a morally significant reason for not keeping

(34) Nel NODDINGS: Caring, op. cit., pp. 36-37.
him alive”. The second and related point is this: the dichotomy drawn between an “ethics of care” and an “ethics of principle” in terms of the distinction between “concreteness” and “abstraction” is a false one: principles need contextual concreteness; and contextual concreteness needs abstraction. The next few paragraphs will show why this is so. After this brief detour, we shall then return to the example of the two Nurses M. and N.

It is difficult to see how ethical thinking can ever proceed, as Noddings puts it, “in isolation from the complicating factors of particular persons, places, and circumstances”. As George Sher has observed, even for the most rigid supporter of absolute principles, facts and circumstances must play some role in moral reasoning. Without such contextual detail, it would be impossible to determine whether a particular act infringes the rule in question (35). Take the rule: “It is always wrong to kill an innocent human being”. Without context, it would be impossible to know whether a particular act breaches the rule: the person killed may or may not have been “innocent” in the required sense; and — unless one adopted a very narrow definition of “killing” — it would be equally impossible to know whether, say, a doctor who administers a lethal injection of morphine, kills the dying patient or, as many an absolutist would have it, merely alleviates her pain.

By the same token, not even those who think of themselves as “situation ethicists” (i.e., where a person’s moral response is determined by the particular circumstances of each individual situation) can do without “abstracting” some details from the contextually rich backdrop against which ethical decisions typically have to be made. Because it is simply not possible to take all the facts, feelings, or each aspect of every personal history into account, a moral approach always requires some abstraction from the total context. Some factors will be regarded as morally relevant — for example that a formerly competent patient expressed some wish regarding his treatment — while others (the colour of the patient’s eyes, for example, or the number of hairs on his scalp) will be ignored as morally insignificant. This means that the question is not whether context is relevant, but

rather what elements of that context ought to be “abstracted” from the overall context as significant for ethical decision-making (36).

Once it is realized that ethical thinking can never be totally context-free and that some abstraction from context is always required, the distinction between an “ethics of care” and an “ethics of principle” becomes one of degree, not of kind. This recognition will also quite naturally shift our focus to a different question — namely to the question of moral relevance. Which factors are morally relevant, and which are not, and what are the reasons for this judgment? Those who approach ethics from the perspective of the justice tradition will focus on aspects relevant to the application of certain principles or rules; those who approach ethics from a consequentialist perspective will focus on certain goals — for example, how much pleasure or pain a given action will produce, or how well it satisfies the preferences of all those affected by the action; and those who approach ethics from the care perspective will focus on questions of receptivity, relatedness, and sensitivity to contextual nuances. What the morally relevant factors are is one of the most central and vexing questions in traditional ethics. Hence, if exponents of a “female ethics of care” are proposing that we select factors or aspects different to those regarded as relevant by proponents of the justice tradition, they are very much on the turf of traditional ethics (37).

The problem is, however, that exponents of an “ethics of care”, whilst quick to reject “principled male ethics” as inadequate, are not providing alternative principles or other adequate guides to ethical conduct to take their place. True, they are suggesting that certain features, such as receptivity, responsiveness, and sensitivity to relationships and to context, are morally significant, but, as I have argued above, these features are best understood as attitudinal or dispositional qualities which cannot, by themselves, tell us what to do. Attitudinal care is morally blind and, as Hilde L Nelson notes, “there is nothing within the concept of care itself that can regulate its force or direct it toward worthy objects” (38). In other words, until and

(36) Loc. cit.
(37) Insofar as this is the intention of proponents of an “ethics of care”, they are not the only critics of the justice tradition. Exponents of other competing ethical theories, utilitarians foremost among them, have also incessantly raised questions about the adequacy of the criteria proposed by the justice tradition.
unless we give principled reasons as to why we should, in the clinical context, focus ethical attention on such things as the patient’s previously expressed wishes, rather than on the number of hairs on his scalp, we have no reason for regarding one as more worthy of our attention than the other.

This brings us back to the case of Mr. Smith and the disagreement between Nurses M. and N. How might it be resolved? The answer must be that it cannot be resolved — unless the nurses engage in some kind of principled reasoning. We can envisage a situation where each nurse provides the other with the most complete “narrative” available, but unless she is able to “abstract” some details from the situation, and show that — and why — these should be considered morally relevant, she will not be able to convince the other nurse of her point of view. As far as ethical discourse is concerned, she will be condemned to silence. On the other hand, if she does “abstract” certain facts from the situation, and is able to defend them as morally relevant, she must do so on universal grounds, in the name of principle — whatever its specific content might be (39).

Those who eschew all principles in moral discourse are — as is revealed in the truly tragic tale of a sensitive and compassionate nurse — condemned to moral silence. In this “personal narrative” of great length and detail, Randy Spreen Parker, who describes herself as a “seasoned critical care nurse”, abandoned principled discourse to “learn the lines of a different script — a script that was written in a universal, relational language”. This “different script”, her discussion

(39) Nel Noddings and others might want to raise an objection here — namely the objection that situations are never sufficiently similar for universal principles to gain a foothold. It is true, principles are only cutting rather crudely, and a principle which is fitting “in the abstract”, will often not be very helpful in practice, where the context may call for a revision of that principle. Soon, Noddings might say, we will have a whole swarm of principles, and seeing that there is no agreed way of hierarchically ordering them, if they clash (as they inevitably will), we will need more and more complex rules to deal with the contingencies of contextually different situations. Such long and complicated rules would not be much use in practice. This criticism of the justice tradition is, however, not new. Consequentialists have long argued that an ethics of hierarchically order principles and rules is theoretically flawed and difficult to apply in practice. R.M. Hare’s two-level approach to ethics offers an alternative and more satisfactory solution. (R.M. Hare: Moral Thinking: Its Levels, Method and Point, Oxford University Press, 1981, esp. pp. 32-34.) See also Jean Grimshaw: “The Idea of a Female Ethic”, op. cit., pp. 205-211. Grimshaw criticizes Noddings for her failure to distinguish between rules and principles.
makes clear, is broadly similar to our notion of “dispositional care”. It allowed her to care for an aphasic patient, Mike, in what seems to have been an admirable fashion and to achieve some deep understanding of his experience of his situation. When it became clear to Mike and the narrator that “further medical interventions served no meaningful purpose”, Parker spoke to the attending physician and head nurse and told them that she “did not feel” that Mike wanted to continue life-sustaining treatment.

I asked to remain Mike’s primary nurse and to care for him, but I explained that I could not participate in any further dressing changes or resuscitation measures. I tried to explain my rationale but found myself fumbling for the right words. How could I translate my own moral experience into traditional moral language? The scripts were different. After several meetings with the attending physician and other nurse managers, I was removed from intensive care and placed on a medical-surgical unit.

Over the next week Mike was resuscitated several times, before he died “in pain, frightened and alone” (40).

Parker’s realization that attitudinal care and “traditional moral language” have radically different scripts which defy translation is of course quite correct. What makes the tale so tragic is that she failed to realize that attitudinal care and a principled approach to ethics are not two alternative ethical theories, but rather two complementary features each of which is indispensable for any adequate ethics. “Dispositional care” will make a nurse receptive to the nuances of a situation; but ethical principles are necessary to capture and justify the ethically significant features of the situation to oneself and others. Without principles of some sort — and it is of course an open question what these principles should be — there can be no ethical discourse, no justification — only unguided feelings which will hold no persuasive power for others.

The result of this mistake was that Parker could not adequately defend “Mike’s” interest. Mike died frightened and alone, and Parker felt compelled to write the story of her “search for a relational ethics of care”.

To believe that “caring” can be the central notion underpinning an “ethics of care” is to make a category mistake, a mistake which confuses the preconditions for ethical action with ethical action itself. This confusion has serious consequences for nursing practice. By eschewing ethical principles, rational discourse and norms, nurses will not be able to press any of the moral claims they think important, and the valuable insights derived from the discussions of care as an attitudinal quality or moral disposition will be lost. The consequences are, of course, much more far-reaching than that. If women subscribe to a “female ethics of care”, they will, at best, talk to each other and continue to play a marginal role, if any, in public life. The feminist literature documents in damning detail the invisibility of women and the neglect of their concerns in all spheres of life. But how are we to defend the interests of women if those who claim to be writing from a feminist perspective reject ethical principles, including such principle as the principle of justice — the very principle on which to base our claims? Principles cannot be used as blunt instruments, in abstraction from context, but to reject them altogether in exchange for a subjective and parochial “ethics of care”, is to advocate the silence of women.

This essay began with the question of whether women and men approach ethics differently. I myself am dubious about the claim that ethics is gendered and that women are inherently more caring than men. Rather, I am more persuaded by the empirical evidence which suggests that differences in moral reasoning are most often linked not with sex, but with class, education, and social role (41). This view is, of course, not incompatible with the empirical claim that nurses and women as a group — because of economical and social forces — do approach ethics more readily from the care perspective than do men. In that sense, then, it may well be correct, as Rousseau and contemporary exponents of a “female ethics of care” have claimed, that women and men approach ethics differently. However, whereas Rousseau suggested that the “male” and “female” approaches com-

plement each other and cannot stand on their own, contemporary exponents of female ethics of care” make the mistake of regarding one of the complementary parts of ethics — attitudinal care — as the whole.

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