The Role of Caring in a Theory of Nursing Ethics
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The development of nursing ethics as a field of inquiry has largely relied on theories of medical ethics that use autonomy, beneficence, and/or justice as foundational ethical principles. Such theories espouse a masculine approach to moral decision-making and ethical analysis. This paper challenges the presumption of medical ethics and its associated system of moral justification as an appropriate model for nursing ethics. It argues that the value foundations of nursing ethics are located within the existential phenomenon of human caring within the nurse/patient relationship instead of in models of patient good or rights-based notions of autonomy as articulated in prominent theories of medical ethics. Models of caring are analyzed and a moral-point-of-view (MPV) theory with caring as a fundamental value is proposed for the development of a theory of nursing ethics. This type of theory is supportive to feminist medical ethics because it focuses on the subscription to, and not merely the acceptance of, a particular view of morality.

INTRODUCTION

During the past ten years, a number of books on ethics in nursing practice have appeared (Benjamin and Curtis 1986; Davis and Aroskar 1983; Jameton 1984; Muyskens 1982; Thompson and Thompson 1985; Veatch and Fry 1987). Unlike earlier writings that viewed ethics in nursing as primarily feminine etiquette (Aikens 1916; Gladwin 1937; Robb 1900), these books view nursing ethics as a subset of contemporary medical ethics. Accordingly, they apply medical ethics to the practice of nursing using frameworks from bioethical theory (Beauchamp and Childress 1983), theologically-based contract theory (Veatch 1981), pluralistic secular-based theory of human rights (Engelhardt 1986), and a well-known, liberal theory of justice (Rawls 1971).

This influence on the development of nursing ethics has been quite extensive. Current nursing ethics discussions tend to revolve around deontological versus utilitarian theories, the weight of medical ethical principles and rules in nurses' decision-making, and the relative importance of nursing's contract with society and individual patients. Empirical studies in nursing ethics have almost exclusively used justice-based theories of moral reasoning from cogni-
tive psychology to interpret their findings on nurses' moral behavior, moral judgment, and moral reasoning (Crisham 1981; Ketefian 1981a, 1981b, 1985; Munhall 1980; Murphy 1976). In addition, medical ethical frameworks guide the majority of normative discussions of ethics in nursing (Cooper 1988; Silva 1984; Stenberg 1978). The result is a trend in nursing ethics that does not take into consideration the role of nurses in health care, the social significance of nursing in contemporary society, or the value standards for nursing practice. By focusing on the terms of justification, gender-biased considerations of justice, and the language of principles and rules, nursing ethics has seemingly adopted the "language of the father," to use Noddings's apt terminology (1984, 1).

This paper challenges the presumption of medical ethics, especially a "masculine" medical ethics, as an appropriate model for nursing ethics. By a "masculine" medical ethics, I mean ethical theorizing and associated argumentation that proceeds as if it were governed by an implicit, logical necessity between hierarchically arranged levels of ethical principles, rules, and actions. Often called "the engineering model" of medical ethics (Caplan 1982, 1983), this type of theorizing has been criticized by bioethicists for a number of years (Ackerman 1980, 1983; Basson 1983; Toulmin 1981). Medical ethics based on this type of theorizing often relies on a lexical ordering of principles (Toulmin 1981) or the context of justification for ethical decision-making rather than the context within which such decision-making takes place (Noddings 1984) or the kinds of reasons that are regarded appropriate to the making of moral judgments (Frankena, 1983).

Drawing on the results of empirical studies on physician and nurse decision-making as well as philosophical discussions of nursing ethics, I show that the theoretical and methodologic foundations of nursing ethics have been largely derived from "masculine" forms of medical ethics. I argue that caring ought to be the foundational value for any theory of nursing ethics. In addition, caring must be grounded within a moral-point-of-view of persons rather than any idealized conception of moral action, moral behavior, or system of moral justification.

If successful, my argument might be significant in two respects. First, it just might be supportive to a feminist medical ethic. While we might agree that medical ethics, in general, ought to be capable of being practiced by both males and females, surely feminist medical ethics necessarily must be capable of being practiced by females. Since the nursing profession, the largest group of health care providers in the United States, has already articulated caring as an important value (Fry 1988; Gadow 1985; Watson 1985) and nursing is usually practiced by females, this means that caring and the type of functions that are usually associated with the practice of nursing are related to one another—at least in the minds of a significant portion of individuals in the health care arena. Hence, the connections between the value of caring and
feminism cannot be easily denied. Since the phenomenon of human caring need not be gender related, any claim to feminist medical ethics must demonstrate that it has broader applications than either just to medical practice or just to females. After all, patients are cared for by individuals other than physicians, and those who do this caring are not always females. A nursing ethic with caring as a foundational value might be an important asset to the perceived need to articulate a feminist medical ethic.

Second, since articulation of the phenomenon of human caring has already challenged justice based theories of moral development and moral judgment (Gilligan 1982, 1987) and theories of ethics and moral education (Noddings 1984), a theory of nursing ethics with a moral-point-of-view of caring as a central value might also challenge any theory of medical ethics that utilizes traditional ethical principles or that depends on the context of justification for determining what is morally right and/or wrong in medical practice. Given the present dissatisfaction with traditional foundations of biomedical ethics, moral-point-of-view theories as well as a caring-based ethic might prove very attractive as the discipline of bioethics moves into the 21st century and faces new tests for its moral foundations and traditional arguments.

TRADITIONAL VALUE FOUNDATIONS OF NURSING ETHICS

Several interesting approaches have been used to identify the moral foundations of nursing and the central value(s) of the nursing ethic. For example, empirical studies of the clinical decision-making of nurses have pinpointed autonomy as a fundamental value affecting moral dimensions of nursing practice (Alexander, Weisman, and Chase 1982; Prescott, Dennis, and Jacox 1987). The results of one other study have suggested that subjective values, such as producing the greatest good for the greatest number, are foundational to nurses' ethical decision-making (Self 1987). Unfortunately, the results of these studies were interpreted in terms of these values as predetermined ideologies for nursing practice. In other words, autonomy and producing good were categories that the researchers expected to find because autonomy and producing good are prominent features of medical ethics. What was assumed to be the case in medical ethics was assumed to be the case in nursing ethics, as well.

This should not surprise us. Both of these values—autonomy and producing good—are prominent features of theories of medical ethics. Engelhardt (1986), for example, posits autonomy as the foundational value of secular bioethics while Pellegrino and Thomasma (1981, 1988) urge the restoration of beneficence as the fundamental principle of medical ethics. As used in these theories, autonomy and producing good constitute idealized value components of a social ethic for the practice of medicine and function within a structured framework of ethical principles and rules for physician decision-
making. Both theories rely on traditional interpretations of their central principles and utilize traditional patterns of moral justification as articulated by leading bioethicists. The same views of autonomy and beneficence have even been claimed by some nurses as the moral basis for needed social reform on the institutional setting in which nursing is practiced (Yarling and McElmurry 1986). However, there is no good reason to assume that autonomy and producing good are, de facto, the appropriate value foundations for the practice of nursing simply because they are accepted for the practice of medicine. While no one would dispute that autonomy and producing good are related to the practice of nursing, neither of these values, derived from theories of medical ethics, have been convincingly argued to be the primary moral foundation(s) of the nursing ethic.

Other approaches to identifying the moral foundations of nursing or the fundamental value of the nursing ethic have been both analytical and normative. For example, Stenberg (1979) analyzes value concepts of several theoretical frameworks in medical ethics for their relevance to the practice of nursing. She analyzes the concepts of code, contract, and context as discussed in the works of May (1975) and Fletcher (1966) and finds them inadequate bases for the nursing ethic. However, the concept of covenant as discussed in the medical ethical works of Ramsey (1970) and May (1975) is adequate as an "inclusive and satisfying model for nursing ethics" (Stenberg 1979, 21). Viewing covenant as the foundational value for such health worker actions as fidelity, promise-keeping, and truth-telling in patient care, Stenberg adopts it without alteration. Because covenant is a moral foundation for the physician/patient relationship, Stenberg considers it valid for the nurse/patient relationship, as well. This tendency to adopt medical ethical frameworks as valid moral foundations for the practice of nursing is repeated in more recent analyses of the moral foundations of the nursing ethic (Bishop and Scudder 1987; Cooper 1988).

Again, what is appropriate to the practice of medicine or is argued as a moral foundation for the physician/patient relationship is not necessarily the case for the practice of nursing or the nurse/patient relationship.

THE MORAL VALUE OF CARING AS A FOUNDATION FOR NURSING ETHICS

Foregoing recourse to medical ethics, a few nurses have attempted to articulate other foundational values for the moral practice of nursing. Sally Gadow (1985), for example, argues that the value of caring provides a foundation for a nursing ethic that will protect and enhance the human dignity of patients receiving health care. Viewing caring in the nurse/patient relationship as a commitment to certain ends for the patient, Gadow analyzes existential caring as demonstrated in the nursing actions of truth-telling and touch. Through truth-telling, the nurse assists the patient to assess the sub-
jective as well as objective realities in illness and to make choices based on
the unique meaning of the illness experience. Through touch, the nurse as-
sists the patient in overcoming the objectness that often characterizes a pa-
tient's experience in the health care setting. To touch the patient is to affirm
the patient as a person rather than an object and to communicate the value of
caring as the basis for nursing actions. This approach identifies a moral foun-
dation for nursing ethics based on the reality of the nurse/patient encounter
in health care. It has also been supported by others who wish to articulate
caring as a foundation of the nurse/patient relationship and its meaning
(Griffin 1983; Huggins and Scalzi 1988; Packard and Ferrara 1988).

Building on the ideas of Gadow, Jean Watson (1985) proposes a slightly
different view of caring as the foundation of "nursing as a human science" (13). Viewing nursing as a means to the preservation of humanity within so-
ciety, Watson posits caring as a human value that involves "a will and a com-
mitment to care, knowledge, caring actions, and consequences" (1985, 29).
Such a view of caring requires a commitment toward protecting human dig-
nity and preserving humanity on the part of the nurse. Caring becomes a pro-
fessional ideal when the notion of caring transcends the act of caring between
nurse and patient to influence collective acts of the nursing profession with
important implications for human civilization. Like Gadow, Watson views
caring as a moral ideal that is rooted in our notions of human dignity. How-
ever, unlike Gadow, Watson's human caring constitutes a philosophy of
action with many unexplained metaphysical and spiritual dimensions. As
such, her view of caring supports her abstract philosophy of nursing but does not adequately support caring as a moral value that ought to be a foundation
for the nursing ethic. The value of caring remains an ideal rather than an
operationalized aspect of nursing judgments and/or actions.

Like Gadow (1985) and Watson (1985), Griffin (1983) posits caring as a
central value in the nurse/patient relationship. She considers caring to be, first, a mode of being. A natural state of human existence, it is one way that
individuals relate to the world and to other human beings. This is not unlike
Heidegger's (1962) notion of care as a fundamental way that humans exist in
the world and Noddings' (1984) view of caring as a natural sentiment of be-
ing human. As a mode of being, caring is natural—a feeling or an internal
sense made universal in the whole species; it is neither moral nor non-moral.

Second, caring is considered a precondition for the care of specific enti-
ties—other things, others, or oneself (Griffin 1983). This means that a con-
tceptual idea about caring exists as a structural feature of human growth and
development prior to the point at which the process of caring actually com-
ences.

Third, caring is identified with social and moral ideals. For example, Wat-
son views caring as occurring in society in order to serve human needs such as
protection from the elements or the need for love. Gadow views caring as a
means to protect the human dignity of patients while their health care needs are met. Thus, caring, a phenomenon of human existence, gains moral significance because it is consistently reinforced as an ideal by those who have responsibility to serve the needs of others (Griffin 1983). Since the practice of nursing is socially mandated to assist the health needs of individuals (American Nurses' Association 1980) and the nurse/patient relationship has undeniably moral dimensions, caring becomes strongly linked to the social and moral ideals of nursing as a profession.

THREE MODELS OF CARING RELEVANT TO NURSING ETHICS

Given these attributes of caring as defined by accounts of the nurse/patient relationship, at least three models are relevant for a theory of nursing ethics which posits caring as a foundational value.

NODDINGS'S MODEL OF CARING

The first model is found in the work of Nel Noddings (1984) and is theoretically based on ethics and social psychology. Building on the work of Carol Gilligan (1977, 1979, 1982), Noddings has combined knowledge of ethics with perspectives on moral development in women. She states her purpose to be “feminine in the deep classical sense, rooted in receptivity, relatedness, and responsiveness” (Noddings 1984, 2), yet she is careful to develop her notion of caring to be applicable to both females and males.

Caring is a feminine value in that the attitude of caring expresses our earliest memories of being cared for—one’s store of memories of both caring and being cared for is associated with the mother figure. However, caring is also masculine in that it involves behaviors that have moral content and that can be adopted and embraced by men, even though it is not in their natural tendencies to adopt such notions. In defining care, Noddings states, “...to care may mean to be charged with the protection, welfare, or maintenance of something or someone” (1984, 9). Rather than an attitude that begins with moral reasoning, it represents the attitude of being moral or the “longing for goodness” (Noddings 1984, 2). Rather than an outcome of behavior, Noddings's view of caring is ethics itself. As such, it is not necessarily gender-dependent but is gender-relevant.

Central to this view of caring are the notions of receptivity, relatedness, and responsiveness: the acceptance or confirmation by the one-caring of one who is the cared-for (receptivity), the relation of the one-caring to one who is cared-for as a fact of human existence (relatedness), and commitment from one-caring to one who is cared-for (responsiveness). Ethical caring is simply the relation in which we meet another morally. Motivated by the ideal of caring in which we are a partner in human relationships, we are guided not by
ethical principles but by the strength of the ideal of caring itself, claims Noddings. Thus, instead of the notions inherent in conditions for traditional moral justification (Beauchamp 1982), Noddings's ethic of caring depends on "the maintenance of conditions that will permit caring to flourish" (1984, 5). It is a person-to-person encounter that ultimately results in joy as a basic human affect within relationships bound by ethical caring.

Scholarship on the caring phenomenon, in general, has been strongly influenced by Noddings's model of caring. Her view has stressed the ethics and morality of caring from a perspective that is definitely gender-related although Noddings herself would undoubtedly deny that she is advocating a "feminist model." Yet, the model's relevance to the practice of nursing remains largely unexplored. For those who recognize the limitations of the bioethical model of ethical decision-making, however, Noddings's model is a rich ground for the future discussion of nursing ethics. It may also prove to be an acceptable model for the descriptive study of ethical decision-making in nursing practice. While its focus on the ethic of caring as feminine might not be attractive to nurses who are not also female, its foundations in the notions of receptivity, relatedness, and responsiveness between the one-caring and the one who is cared-for make it a viable framework for the realistic nature of the nurse/patient relationship.

PELLEGRINO'S MORAL OBLIGATION MODEL OF CARING

Edmund Pellegrino, a humanist and physician, has written extensively on caring as a derivative value of the physician's obligation to do good (1985; Pellegrino and Thomasma 1988). When discussing the role of the physician to the patient, Pellegrino notes that there are at least four senses in which the word "care" is understood by the practice of medicine (1985). The first sense is "care as compassion" or being concerned for another person. This is a feeling, a sharing of someone's experience of illness and pain, or just being touched by the plight of another person. To care in this sense, according to Pellegrino, is "to see the person who is ill" as more than the object of our ministrations (1985, 11). He or she is "a fellow human whose experiences we cannot penetrate fully but which we can be touched by simply because we share the same humanity" (Pellegrino 1985, 11).

The second sense of caring is "doing for others" what they cannot do for themselves (1985). This entails assisting others with the activities of daily living that are compromised by illness (for example, feeding, bathing, clothing, and meeting personal needs). Pellegrino recognizes that physicians do little of this type of caring but that nurses and nurses' assistants do a great deal.

The third sense of caring discussed by Pellegrino is caring for the medical problem experienced by the patient (1985). It includes: (1) inviting the pa-
tient to transfer responsibility and anxiety about what is wrong to the physician, (2) assuring that knowledge and skill will be directed to the patient's problem, and (3) recognizing that the patient's anxiety needs a specialized type of caring that is presumed available from a physician.

Pellegrino's fourth sense of caring is to "take care" (1985, 12). This means to carry out all the necessary procedures (personal and technical) in patient care with conscientious attention to detail and with perfection. He finds this a corollary of the third sense of care but argues that it is differentiated from the third sense by its emphasis on the craftmanship of medicine. Together, the third and fourth senses of caring comprise what most physicians understand as competence.

Pellegrino does not find these four senses of caring separable in clinical practice. Care that satisfies the four senses that he has defined is called "integral care" (1985). This type of care is, for Pellegrino, a moral obligation of health professionals. It is not an option that can be exercised or interpreted "in terms of some idiosyncratic definition of professional responsibility" (1985, 13). The moral obligation to care in this manner is created by the special human relationship that brings together the one who is ill and the one who offers to help (1985).

In assessing whether the caring model is foundational for medical practice, Pellegrino reexamines the roles of physicians to their patients and concludes that "to care for the patient in the full and integral sense, requires a reconstruction of medical ethics" (1985, 17). What is needed, he claims, is an ethic that attends to the concept of care in its broadest sense and that makes caring a strong moral obligation between patient and professional. Instead of a relationship of curing between physician and patient, a relation of caring is needed to express the nature of the obligation between physician and patient.

Underlying Pellegrino's notion of care is the good of the individual, a complex notion that has at least three components. For Pellegrino, "a morally good clinical decision should attend to all three senses of patient good and satisfactorily resolve conflicts among them" (1985, 20).

The first sense of good is "biomedical good"—the good a medical intervention can offer by modifying the natural history of disease in a patient. It takes into consideration the craftmanship of physicians (and presumably, nurses), of science, and the medical indication for treatment (1985, 21).

The second sense of good is the patient's concept of his or her own good. It takes into consideration what patients consider worthwhile, or in their best interests, and can be designated to surrogate decision-makers (1985, 21).

The third sense of patient good is "the good most proper to being human" (1985, 22). For Pellegrino, this is the capacity to make choices, to set up a life plan, and to determine one's goals for a satisfactory life. It is whatever fulfills our potentialities as individuals of a rational nature, respects patient dignity, and expresses human freedom.
In comparing these three senses of patient good to one another and to our ideas of social good, Pellegrino argues that patient good is prior to any other notion of good within the practice of medicine. Within a human obligation model of caring, patient good ultimately guides a physician's decision-making where a patient's health and illness are concerned. Hence, while the senses of caring engender desirable physician behaviors with the patient, the physician's decision-making is primarily guided by the notions of patient good. In the final analysis, Pellegrino's "integral caring" is reduced to a derivative value of patient good. It succumbs to typical medical ethical frameworks by utilizing a more general (and traditional) value as the foundational value for a theory of medical ethics. Rather than a theory of caring, Pellegrino actually proposes a theory of patient good that simply uses caring to operationalize patient good.

While Pellegrino's ideas about caring, in general, fit in with the practical sense of nursing practice, caring's subordinate role within his theory of medical ethics makes it problematic for nursing ethics. For nursing, caring seems to be more than a mere behavior between nurse and patient and might not always be derived from a notion of patient good. For example, even when the good of the patient is undecided or unknown, the nurse carries out interventions designed to care for the patient (as in emergency situations). Conversely, even when the patient's good has been made evident, nursing interventions may be carried out that do not, in fact, contribute to this sense of patient good (for example, when the physician's interpretation of the patient's good is not accepted by those planning and administering nursing care for the patient). The value of caring, for the nurse, extends beyond the notion of patient good as conceived by Pellegrino because nurse caring relates to the patient's status as a human being (Gadow 1985; Griffin 1983). For this reason, Pellegrino's moral obligation model of caring is not truly appropriate to the practice of nursing.

FRANKENA'S MORAL-POINT-OF-VIEW THEORY ON CARING

The third and final model of caring relevant to the development of nursing ethics is the moral-point-of-view (MPV) version. It is largely discussed by William Frankena in his critique of other MPV theories (1983) and entails adopting a certain point of view by defining its moral principle or central moral value. The result is a type of ethical theory (MPVT) for which Frankena seems to be a major spokesman.

In essence, one takes a moral-point-of-view by (1) subscribing to a particular substantive moral principle (or value) and (2) taking a general approach, perspective, stance or vantage point from which to proceed. While most MPV theories contain views about moral judgments and principles, about the differences between them and nonmoral principles, and views about the gen-
eral nature of their justification, taking the MPV, by itself, simply means to adopt a moral principle (or value) and one's methodology to argue for that principle. It entails endorsing a general outlook or method by someone seeking to reach conclusions in a particular field (Frankena 1983).

According to Frankena, various moral principles have served as the central principles (or values) of MPV theories. Mill, for example, accepts a principle of utility that is pivotal to his MPV theory—that of utilitarianism (1863). Mill starts with a particular outlook (his moral point of view) and adopts the principle of utility as the moral principle that indicates the kinds of facts that one would make moral judgments about. Frankena, however, argues for taking the MPV more fully than simply accepting a certain view of morality. For him, taking the MPV entails not only acceptance of a particular view of morality but entering the moral arena oneself, "using moral considerations of the kind defined as a basis for evaluative judgments" (Frankena 1983, 70). It means subscribing to a particular view of morality and living that morality in one's life rather than merely accepting a certain view of morality and the conditions for the separation of the moral from the nonmoral.

This is a significant move for Frankena as it establishes the crucial difference between his conception of taking the MPV and the approaches of others who espouse MPVs and their related theories. Like Hume (1751) who espouses sympathy as his "sentiment of humanity," Frankena believes that there is always something that "moves us to approve or disapprove of persons" (1983, 70). This something is an attitude or precondition that is ultimately the source or motivating factor of anyone who takes the MPV. In other words, the setting forth of any particular fact is not so much the reason for deciding what is good and right in taking the MPV as is what generates the setting forth of that particular fact (and not some other fact).

For Frankena, this attitude or precondition concerns the fundamental status of persons and their human dignity. While he never explicitly defines what this attitude or precondition is for his own MPV, he eventually claims that this attitude generates the MPV of Caring or, as he puts it, "a Non-Indifference about what happens to persons and conscious sentient beings as such" (1983, 71). Frankena's substantive moral value is the value of caring and takes the form of Kantian respect-for-persons or Christian love. It includes making normative judgments and a concern for being rational in one's judgments but does not entail the acceptance or use of any particular test of justifiability, validity, or truth. A judgment based on caring is assumed to be morally justifiable because it "would be agreed to by all who genuinely take the MPV and are clear, logical, and fully knowledgeable about relevant kinds of facts (empirical, metaphysical, or whatever)" (1983, 72).

Frankena's view on caring is quite different from the view of Pellegrino. Where Pellegrino's notion of patient good provides the basis for the physician's evaluative judgments, Frankena posits caring as the basis of human
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normative judgments, in general. His focus on caring is direct and involves taking the MPV toward caring as a fundamental moral value or principle for normative judgments involving persons rather than the indirect focus on caring (through patient good) that is characteristic of Pellegrino’s medical ethics. Like Noddings, Frankena eschews the structures of moral justification that typify traditional medical ethical theorizing and the separation of the conditions for justification from the context of ethical decision-making with persons. Where much of moral philosophy takes the MPV by simply acting on principle or out of duty, Frankena’s MPV requires a human response from the one taking the MPV in the form of respect-for-persons or Christian love. It requires an identifiable form of response from the one-caring to the one cared-for, to use Noddings’s terminology.

Unfortunately, Frankena makes no attempt to define exactly what he interprets as respect-for-persons and certainly does not discuss his principle of caring in terms relevant to feminist philosophy. However, he does indicate that adopting the MPV of caring is made from an undefined preconditional attitude toward personhood and human dignity. This is not unlike Noddings’s notions of receptivity, relatedness, and responsiveness which anchor her view of ethical caring. While it would not be appropriate to interpret Frankena’s view of caring as identical or even similar to Noddings’s view, certainly his method of arriving at caring as a lived principle for a system of morality (taking the MPV) bears some relevance to Noddings’s views and a feminist approach to medical ethics.

CONCLUSIONS

Given the models of caring proposed by Noddings (1984), Pellegrino (1985), and Frankena (1983), and the views on caring that have been developed by nurses (Gadow 1985; Griffin 1983; Watson 1988), several recommendations for the future development of a theory of nursing ethics and any system of feminist medical ethics seem relevant.

First, theories of medical ethics as currently proposed do not seem appropriate to the development of a theory of nursing ethics. The context of nursing practice requires a moral view of persons rather than a theory of moral action or moral behavior or a system of moral justification. Present theories of medical ethics have a tendency to support theoretical and methodological views of ethical argumentation and moral justification that do not fit the practical sense of nurses’ decision-making in patient care and, as a result, tend to deplete the moral agency of nursing practice rather than enhance it. Any theory of nursing ethics will need to consider the nature of the nurse/patient relationship within health care contexts and adopt a moral-point-of-view that focuses directly on this relationship rather than on theoretical interpretations of physician decision-making and their associated claims to
moral justification for this decision-making. The same might be said for any theory of feminist medical ethics, depending on how the nature of the relationship between the one-caring and the one who is cared-for is perceived.

Second, the value of caring ought to be central to any theory of nursing ethics and any theory of feminist medical ethics, as well. Given the need for nursing care within our society, nursing's perceived social mandate to provide the "diagnosis and treatment of human responses to actual or potential health problems" (American Nurses' Association 1980, 9), and the nature of the nurse/patient relationship, nursing has a significant opportunity to influence the quality of patient care through the acceptance and use of its theories. The profession of nursing has already made substantial commitment to the role of caring in several conceptions of nursing ethics and nursing science. In addition, there appears to be an important link between the value of caring and nursing's views toward persons and human dignity. As proposed by Frankena, there is good reason to subscribe to a MPV that is rooted in an attitude of respect toward persons. If a theory of nursing ethics is to have any purpose, it must necessarily make evident a view of morality that not only truly represents the social role of nursing, as a profession, in the provision of health care but that also promises a moral role for nursing in the care and nurture of individuals who have health care needs. For theory to achieve this purpose, its view of morality ought to turn on a philosophical view that posits caring as a foundational value rather than a derivitive value. The same might also be said for any theory of feminist medical ethics that uses caring as a gender-relevant (but not gender-dependent) moral principle or value.

Third, taking the moral-point-of-view and developing a MPV theory need not necessarily include the acceptance or use of any particular test of moral justification. This means that any theory of nursing ethics need not endorse typical frameworks of justification contained in theories of medical ethics for moral judgments made within its parameters to be regarded as true, valid, or rationally justified. It is true that such judgments must be justified within the MPV and pertain to the sorts of facts considered relevant according to the MPV theory. However, the MPV of the theory of nursing ethics itself is not defined by reference to such a system of justification. This means that feminist models of moral decision-making with similar views about moral justification may have particular relevance to the development of nursing ethics and vice versa.

To the extent that any theory of nursing ethics takes seriously the claims of MPV theorizing and the role of caring as a central value within its framework, there is reason to believe that medical ethics will benefit for such a theory cannot develop apart from the practice of medical ethics or from the evolution of bioethics as an applied ethics discipline. Likewise, claims to feminist medical ethics cannot be made apart from all health care practices (medicine as well as nursing) and necessarily draw on the development of moral thought
within bioethical theorizing. Perhaps the links between all three types of theorizing are more important than currently realized.

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