Care-Based Reasoning, Caring, and the Ethic of Care: A Need for Clarity

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The concept of “human care” or “caring” has long been of interest in the human sciences and humanities. Anthropology, psychology, and sociology have studied human caring in different cultures, and philosophy and linguistics have conducted analyses of the concept to define it and determine its attributes. Benner and Wrubel defined caring as a primary and essential concept that “sets up the condition that something or someone outside the person matters and creates personal concerns.”1 Others have described caring as a “value,” a “virtue,” an “attitude,” an “ideal,” a “behavior,” a “skill,” a “life force,” and a “process.”2 Others have described care as a “way that humans exist in the world,” a “human science,” a “voice,” a “moral orientation,” and an “ethic.”3

In the bioethics literature, the terms “care” and “caring” are often used interchangeably to describe a form of ethical reasoning, a set of behaviors, and a feminist theory of ethics. These have been of interest to many moral theorists because of the limits of traditional ethics regarding moral obligations within intimate relationships. Feminist moral theorists have also criticized the theories of moral development and morality that have been constructed from the moral experiences of men. After Carol Gilligan published *In a Different Voice: Psychological Theory and Women’s Development*, some contemporary moral theorists and researchers have used the “women’s voice” in their works.4 Nursing (still practiced largely by females) has eagerly embraced the concepts of care and caring.5 Even bioethics theory has included ethic of care and caring as a type of theory, albeit an underdeveloped one, that may be relevant in healthcare decision making.6

There is, however, growing criticism of the use of the concepts of care and caring in moral theory, healthcare decision making, and nursing ethics.7 Critics have charged that care and caring are hopelessly vague and ambiguous, and are too incomplete and insufficient to provide an infrastructure for nursing ethic theory.8 Others have argued that the ethics of care is dangerous, distracting, and counterproductive for professionals like nursing,9 as well as an “anti-intellectual kind of ethic in that it tries not only to value feeling over thought . . . but . . . would almost entirely substitute feeling for thought.”10

Many of these criticisms have been justified. The concepts of care and caring *are* vague and ambiguous, and the terms “care” and “caring” have been used indiscriminately. They have been used to describe everything in human relationships; as a result the meaning and roles of care and caring in moral discourse have become confused. To make matters worse, some of the criticism has been based on a lack of knowledge of the issues and on grossly inaccurate interpretations of the literature.11

In this article, we will examine care-based reasoning, caring, and the ethic of care, in turn, in order to
distinguish them from one another. We will also analyze the empirical research about care-based reasoning and caring, as well as theory about the ethic of care. Our intention is to diminish some of the confusion and to identify needed topics for discussion and research.

I. CARE-BASED REASONING

DEFINITION

“Care-based reasoning” (also called care ethics, and moral orientation of care) is a type of reasoning that may be used to resolve ethical conflict, to reach solutions to ethical questions, and to decide what one ought to do in a particular situation. The application of care-based reasoning includes: identifying the moral conflict or problem within its context; considering the others who are involved in the conflict and how they are interrelated; feeling concern for relationships and individuals, which may be expressed as sympathy, compassion, or friendship; and identifying oneself in relation to the individuals and problems involved. The actions and judgments made using care-based reasoning must be measured against what it means to be “caring” within the context of the responsibilities the decision maker has to others. Care-based reasoning does not involve the application of abstract ethical principles to the situation or impartiality on the part of the decision maker. Neither does it involve mindless emotionality and following one’s gut feelings, as some have asserted. In care-based reasoning, moral responsibility and possible choices of action are defined by the context of the situation at hand and the relationship of self to the others involved in the conflict.

Care-based reasoning may be seen as occurring within Component 2 of James Rest’s four-component model of morality: formulation of a morally defensible course of action. Rest based this model, in part, on Lawrence Kohlberg’s hierarchical model of moral development, which appealed to principles of ethics; yet Rest described Component 2 as “determining what course of action would best fulfill a moral ideal, what ought to be done in the situation.” This description leaves room for both care-based reasoning and the more traditional principle-based reasoning as ways to formulate morally defensible courses of action.

Care-based reasoning is often juxtaposed to justice-based reasoning, perhaps because there is a common misapprehension that the principles of care and justice are opposites, that the feminine and the masculine are opposites, therefore feminine care-based reasoning is the polar opposite of masculine justice-based reasoning.

In her pioneering work, In a Different Voice: Psychological Theory and Women’s Development, Carol Gilligan described “care” and “justice” as different—but not necessarily opposite—moral perspectives, or forms of moral reasoning. To examine the relationship between moral judgment and action, Gilligan presented college students with various moral conflicts and asked them about their choices; she also studied pregnant women who were considering abortion. She posited that the justice perspective is one way of seeing moral conflict, and the care perspective is an “alternative vision or frame” for examining the same conflict. Gilligan observed that shifting attention from concerns of justice to concerns of care could change the definition of a moral problem, and could allow the conflict to be seen in different ways. She did not assert that one way of seeing (caring versus justice) was better than another, or that discerning individuals would see a conflict one way rather than another. She reported that moral conflicts could be seen from both the justice and the care perspectives, by the same person, and that both perspectives contained important moral injunctions. She wrote, “justice and care as moral perspectives are not opposites or mirror images of one another . . . these perspectives denote different ways of organizing the basic elements of moral judgment: self, others, and the relationship between them.” Gilligan called for research to determine whether people could alternate in using the care and justice perspectives or integrate the two in an unambiguous way to resolve moral conflicts.

THE RESEARCH

An analysis of care-based reasoning studies by one of us (ARK) reveals interesting information about the care and justice orientations. Several researchers have attempted to measure the care orientation of women, as described by Gilligan and echoed by the work of female moral theorists. Presumably, these researchers sought to demonstrate the existence of the care orientation among women before they conducted further
studies that contrasted the use of the care orientation by females and males. Two instruments, the World View Questionnaire (WVQ) and the Ethic of Care Interview (ECI), were successful in measuring the care orientation in women in several studies. Additional studies using the ECI have reported significant relationships exist between ego identity and use of the care orientation among women.

Researchers have followed up on Gilligan’s theories regarding the ways people use the care and justice perspectives. One study reported that males tended to use the justice perspective and females tended to use the care perspective; another did not. Several studies have reported that men and women tend to use both the care and justice perspectives in their reasoning about moral conflict, but that they primarily use one orientation, and that men focus on considerations of justice and women focus on considerations of care. Three studies support Gilligan’s finding that the use of the care and justice perspectives appears to be related to the type of moral conflict to be resolved.

ARK notes that caution must be used in interpreting the results of these studies: the measures used in the studies were often not well-developed, reliable, or valid; and that some study results were based on small sample sizes. Finally, the use of hypothetical dilemmas in the studies has generally been unsuccessful in showing gender differences in moral reasoning. This may be due to the measurement tools developed for the studies or due to the nature of the dilemmas presented. In sum, a number of empirical studies have reported that people do use the care perspective in moral reasoning, but further research is needed.

II. CARING

DEFINITION

As we have noted, “caring” can be defined and described in many ways. “Caring” can be a value (as well as something that is valued) and may have both moral and non-moral dimensions. Caring, it can be argued, can be an ethical principle as well as a moral virtue. Unfortunately, these views have not been carefully developed in the literature. The concept of caring has not been adequately analyzed, nor have its various attributes been identified and distinguished from other closely related attributes of similar concepts.

As this is the case, we will limit our discussion to the analysis of caring behaviors in the nursing literature. We will define caring as a behavior or set of behaviors that stems from a strong opinion, feeling, concern, or interest in something or someone and that contributes to the good, worth, dignity, or comfort of someone. This allows us to consider what might be truly called “caring behavior,” not just those behaviors that are practiced in a particular role that has traditionally been considered to be a caring role--nurse, parent, physician, and so on--nor just those various tasks and skills that are performed in a caring manner. We will comment further on as we review the empirical research conducted in this area.

THE RESEARCH

The Warren study. In 1988, L.D. Warren reviewed and synthesized nine research studies on caring. She identified 34 different aspects of caring behavior; she reported that patients, nurses, and the general population were in agreement on the majority of these aspects. The studies she reviewed included seven qualitative and two quantitative methodologies, and, combined, included data from 221 patients, 188 nurses, and 310 persons from the general population. Only patients identified these aspects of caring: “timely, gentle, careful”; “checks patient often”; “is well organized”; “being considerate”; “being understanding.” Only nurses identified: “counseling”; “planning for the future”; “supplies resources”; “is aware of safety”; “collaborates”; as aspects of caring.

The aspects of caring listed in Warren’s study are behaviors as well as specific skills that are related to nursing competence. Many are not relevant outside the context of healthcare (“assists with pain”; “does health teaching”; “does assessments”; “checks patient often”; “gives good physical care”; “knows when to call MD”). What is it about many of these behaviors that makes them caring behaviors, rather than typical nursing behaviors? Some seem more related to nursing skills and nursing tasks than to anything else. Some of the behaviors could be practiced in a caring manner as well as in an uncaring manner. If a nursing task is practiced
in a caring manner, does this make it a caring behavior? No; we cannot assume that nursing behaviors are caring behaviors because they are practiced by nurses; nor can we assume that any nursing task done in a caring manner is a caring behavior. It is also clear that some of the behaviors identified by Warren are not necessarily nursing behaviors; they are caring behaviors that can be practiced by anyone. What is it about some behaviors that we call them “caring behaviors”? 

New analysis. One of us (EMR) analyzed nine other studies and identified 26 aspects of caring nurse behaviors. Several of these aspects appear in at least four of the studies; “presence” (a physical and emotional commitment of the nurse to the patient) appears in four studies;27 three other aspects appeared in several studies: “competent delivery of nursing care,” “trusting relationship,” and “empathic communication” (a connectedness between the nurse and patient and communication that is not one-sided or devoid of feeling).28

The last three aspects are similar to several of the aspects that were identified by Warren: “competent delivery of nursing care” is similar to Warren’s “specifically knows procedures” and “knows when to call MD”; “trusting relationship” is similar to Warren’s “has good relationship with patient”; “empathic communications” is similar to Warren’s “listens” and “talks.”

The aspects of caring identified by these studies are more abstract than those identified by Warren. They tend not to describe observable nursing tasks (such as “checks patient often”). When we eliminated nursing tasks and skills from Warren’s list and combined similar aspects from Warren’s and EMR’s lists, we identified 11 aspects as a list of caring behaviors (presented in table 1). This is a preliminary list, open to interpretation. It provides, however, a starting point for further discussion and research on what constitutes caring nurse behavior, and caring behavior in general, in the eyes of the patient and in the eyes of the public.

III. THE ETHIC OF CARE

DEFINITION

The ethic of care is often confused with care-based reasoning and the moral orientation of care. Any ethic, however, must be more than a form of reasoning or moral orientation. We define the ethic of care as an alternative normative ethical theory for deciding what is right and wrong, good or bad, or obligatory in human relationships. Like any ethical theory, an ethic of care posits standards for what is morally right and wrong, and good or bad, and proposed theories of obligation, of the good, and moral justification.29

THE THEORY

Noddings. It is unfortunate that ethic of care theory has been developed by only one person, and her views have not be widely accepted (and for understandable reasons). Nel Noddings’s book, Car- ing: A Feminine Approach to Ethics and Moral Educa- tion, published in 1984, includes notions about moral obligation, moral good, and moral justification. Noddings views the ethic of care as a type of virtue theory in which the virtue of care involves both natural and ethical caring. For Noddings, moral ideals are preferable to ethical principles as guides to moral action. However, an ethic based on virtues, even though virtues are necessary for right conduct, is not usually considered adequate to ensure right con- duct.30 Because each person’s ethical ideals are subjective, the practical use of an ethic based on virtue theory in actual situations of moral conflict is consid- ered suspect, if not somewhat arbitrary.

Moral theorists, who have been strongly influ-
enced by traditional approaches to moral obligation, find Noddings’s notion of obligation, which she couched in terms of the “I must” and the “I ought,” difficult to accept. Moreover, the “I must” and the “I ought” are less likely to be used as guiding ethical standards than, say, autonomy or doing good. Also, Noddings’s examples of moral obligation are presented in terms of feelings and the mother-child relationship, that may make the ethic of care sound like a theory that is for women, or is “anti-intellectual,” as some have charged.31

Noddings’s notion of moral good, of what is right and wrong, depends on the development of certain feelings in early childhood. Without these feelings, she asserts, it is impossible for a person to develop “the caring attitude that lies at the heart of all ethics behavior . . .”32 Her notion of moral justification depends on motivation to act in accordance with the ideal self, which develops from having been cared for and from remembering having been cared for. Moral acts do not require justification; one’s actions complete another’s sense of feeling cared for, or they do not. One’s actions either enable another to act in a caring way, or to get on with one’s purposes in the circles in which they are defined, or they do not. Moral acts are obligations that are completed in another. If justification for an action is ever required in the ethic of care, it is the non-caring action that requires justification, as not caring for another reduces one’s own ethical ideal and ethical self.

Blustein. Other moral theorists have argued that the basis for a full-blown ethic of care might be found in the works of Hume, Aristotle, or in some variation of deontological theory, but none of these approaches has been developed.33 Jeffrey Blustein has probably given the most serious philosophical thought to a ethic of care theory in his recent work on the connections between care and commitment, personal integrity, and intimate relationships.34 Calling his approach “taking the personal point of view,” Blustein carefully analyzes key notions such as caring, the good of care, integrity, and intimacy. He is well on his way to defining a defensible theory of the good and a theory of moral obligation for a future ethic of care.

CONCLUSIONS

Blustein and others have rightly criticized traditional moral theory for its inadequacies in accommodating the demands of special relationships—relationships that are shaped by changing social roles and changing definitions of what constitutes a relationship of obligation, a family, and a community. Our great moral theorists of the past did not envision the moral challenges that new technologies would create in healthcare and in all aspects of our lives. Care-based reasoning, caring, and the ethic of care are contemporary responses to the need for new moral theories adequate for the moral questions we all face. Careful analyses of them is essential for this work to proceed. We hope that the suggestions presented in this article are useful to others in their work.

NOTES


8. For these particular criticisms, see Almark, “Can There Be an Ethics of Care?” 19; Loewy, “Care Ethics” 56.


11. Ibid. Loewy’s criticisms, in particular, are based on a superficial look at the care/caring literature and a lack of knowledge of what feminine moral theorists and philosophers have contributed to the debates about care/caring. He also seems to think that Noddings’s view of care ethics is the predominant view and that everyone accepts it.


13. Friedman, “Care and Context,” 203. Gilligan does not call the care orientation a form of moral reasoning. However, other feminist moral theorists, such as Friedman, do.


16. Gilligan, *In a Different Voice*.

17. Ibid., 20.


21. For the WVQ, see Jensen, McGhie, and Jensen, “Do Men’s and Women’s World-Views Differ?” For the ECI, see Skoe and Marcia, “A Measure of Care-Based Morality.” The WVQ was tested by V. Stander and L. Jensen. The ECI was tested by Skoe and Marcia, Skoe and Gooden, and Skoe and Diessner.

22. Skoe and Marcia, “A Measure of Care-Based Morality”; also, Skoe and Diessner, “Ethic of Care.”


Ethics of care, also called care ethics, is a feminist philosophical perspective that uses a relational and context-bound approach toward morality and decision making. The term ethics of care refers to ideas concerning both the nature of morality and normative ethical theory. Such a relation can certainly be more than merely dyadic (an influence-based relationship between two people) as the one-caring and the cared-for may come to exhibit reciprocal commitment to each other’s well-being. However, what is distinctive in all such relations is that the one-caring acts in response to a perceived need on the part of the cared-for.
Objectivism = rationality Ethic of Care = empathy (empathy can be irrational). A caring response that is ____ takes into account the needs of the decision-maker himself or herself as well as the needs of ______. The response splits the difference between the extremes of (caring for others at the exclusion of self), on the one hand, and (caring for self to the exclusion of others), on the other hand. morally mature others codependence selfishness. --> take into account both your needs & the needs of others. The caring decision-maker focuses on the __ relationship and context invol