# The Ethics of Caring

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THERE IS a growing litany of criticism to which health care providers have been increasingly exposed. One criticism among these involves issues that should be of primary concern to all of us, for they are the central and unifying focus of all health care providers: the phenomenon of care, the caring process and caring consequences. The charge of dehumanization by health care providers and the resulting depersonalization of the patient/client strikes at our professional commitment to provide both competent and caring help to the maimed, the injured and the diseased.[1]

This basic dictum to be compassionate, humane and caring toward those for whom we provide care is most often expressed in the phrase "treat the person not merely the patient." To be concerned with the "whole person" and to practice with consideration and sensitivity for the integrity of the human self is basically an ethical injunction.[2] Caring, as a professional and personal value, is of central

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importance in providing a normative standard which governs our action and our attitudes toward those for whom we care.

## THE EROSION OF CARE

The two factors that seem most pertinent to the process of caring are specialization and the development of science and technology.

### *Specialization*

The trend toward specialization and institutionalization in medicine, nursing and other allied health care professions has resulted in a bewildering division and subdivision of tasks and claims to expertise. The vast superstructure of our highly institutionalized bureaucracy is inherently depersonalizing. The individual easily becomes lost in the maze of rigid and uniform regulations applied to all with an impersonal and many times apathetic hand.

The social milieu of most large teaching hospitals and clinics reflect what Goldsborough characterizes as a "no care" society.[3] Patients are at the mercy of strangers whose roles they do not and may never understand, and unfamiliar machines and alien routines that seem totally out of step with their own habits. The patient "becomes just another patient, another disease, another medication order, another name on the daily operating room schedule.... He is required to discard his identity as a person and become a 'patient'."[3(p66)]

It is perhaps not an altogether unreasonable observation that "Few people have a hospital experience without feeling to some degree depersonalized and deprived of basic human rights and dignities."[4(p314)] The health care team approach has in many ways been a reasonable response to the rapidly proliferating science and technology in the health care field. It has become almost a necessity in diagnosis and treatment. On the positive side, it must be acknowledged that there are many people alive today that might not be if it were not for these specialists' teams. However, the emergence of teams has raised serious issues about the relationship between and among the various professional team members and the team's influence on the quality of care provided to the patient.

Perhaps a more serious concern related to the specialized team approach is the tendency to devalue the individual. The parceling out of the patient to various team members has undoubtedly contributed to the increasing fragmentation and impotence felt in any encounter with the health care system.

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### *The Development of Science and Technology*

The "spirit of the age," or *Zeitgeist* as the Germans call it, of the 20th century has been the scientific method and its visible, material product, technology. The discoveries of medical and biological science,

and the resulting technological applications, are successes of which modern medicine is justly proud. There is little doubt that future discoveries are certain to extend even further our knowledge of humans as objects of science.

Yet beneath this justifiable pride of accomplishments, certain events conceived in these same scientific successes have created a disquietude. Health care providers are in danger of generalizing scientific and technical expertise into the realm of individual patients' values and beliefs. The exercise of authority by health professionals, conferred by the power of clinical science and technology, carries with it the frightening potential of overshadowing individuals, reducing them to objects or abstractions, and of becoming an instrument of tyranny—when untempered by a humanistic value system.[5] There is a clear and present danger—considering the possibilities of genetic manipulation, behavior control and organ transplantation—of a failure to make clear the distinction between what *is* and what *ought* to be. "We cannot," Pellegrino cautions, "use the awesome powers of medicine humanely without rethinking our idea and images of man, and the value and purposes of his existence."[5(p14)]

The delivery of health care, regardless of how competently the specific tasks are carried out in relation to a given patient, or how consistent with the latest scientific knowledge it is, is often perceived by the client as lacking the "poignant personally experienced feeling of being cared for."[6(p837)] The quality of care is something quite separate from outcome of treatment. What we have gained in our understanding of humans, biological and material objects, is inversely accompanied by a diminishing identity and sense of self.

There is much in literature about this mixed blessing of science. The Frankenstein myth is a compelling metaphor that describes how scientific and technological success has reduced rather than enhanced our humanity. The story of Dr. Victor Frankenstein and the monster he created is, on the surface, a novel of tensely mounting horror. On a more profound level, it offers a searching inquiry into the human condition. Although a grotesque exaggeration, it reflects the author's philosophical concern about peoples' constant striving for knowledge and control over the forces of nature.

Working alone in his laboratory, Dr. Frankenstein, finding that "the minuteness of the parts" was a hindrance, resolves to make his creature "about eight feet in height and proportionally large."[7(p52)] As he works, he speculates that with his success "a new species would bless me its creator and source; many happy and excellent natures would owe their being to me. . . . I might in process of time . . . renew life where death had apparently devoted the body to corruption."[7(p52-53)] Yet when the dull yellow eyes of his creature open he is filled with disgust and horror. Frankenstein's tragedy was not his scientific triumph over nature, but his *failure to care* for what he had created. He was unable to recognize or experience the humanness of another's self.

## THE PROCESS OF CARING

In a world in which there is a great deal of loneliness, pain, suffering, illness and tragedy, the need for care has become

essential. Although the concept of curing is perhaps the dominant focus in health care, Leininger maintains that "caring acts and decisions make the crucial difference in effective curing consequences. Therefore, it is caring that is the most essential and critical ingredient to any curative process."[8(p2)]

With dominant emphasis on curing, most discussions of health care or quality of care neglect the concept of "caring." Dictionary definitions of caring include a sense of close or careful attention, a sense of watchful responsibility, custody or management, a feeling of love or liking. Sobel defines human caring as "that feeling of concern, regard, respect, one human being may have for another."[9(p2612)] Caring includes a component of self-respect or dignity. Gaylin argues that an impulse for caring is biologically programmed in human nature.[10] This caring impulse may be impaired or reinforced by environmental circumstance.

Mayeroff describes caring as "a process, a way of relating to someone that involves development . . . in time through mutual trust and a deepening and qualitative transformation of the relationship."[11(p1)] The meaning of caring, he suggests, "is not to be confused with such meanings as wishing well, liking, comforting and maintaining . . . it is not an isolated feeling or a momentary relationship. . . ."[11(p1)]

Mayeroff explores what he describes as a general pattern of caring. In a caring relationship a person or an idea is experienced both as an extension and as something separate from oneself. One experiences what is cared for as having a dignity and worth in its own right with potentialities and need for growth. Caring is the antithesis of possessing, manipulating or dominating, a process which requires devotion and trust. In any actual instance of caring there must be someone or something specific that is cared for. Caring cannot occur by sheer habit; nor can it occur in the abstract.[11]

### *Major Components of Caring*

Mayeroff further examined the concept of caring by describing what he identified as eight essential ingredients.

*Knowledge* that is both general and specific is required, since caring is not simply a matter of good intentions or warm regards. Caring includes explicit and implicit knowledge, knowing that and knowing how, and direct and indirect knowledge.

*Alternating rhythms* is the moving back and forth between a narrower and a wider framework. It is being able to maintain or modify behavior according to variations in circumstance or perspective.

*Patience* is a kind of perceptive participation with the other in which there is a sense of the other's own time and style. Patience is contrasted with a passive waiting for something to happen.

*Honesty* is a positive, active confrontation and being open to oneself and to the other rather than a matter of *not* doing something, such as not deliberately deceiving others.

*Trust* involves the appreciation of the independent existence of the other. Trusting the other is to let go and includes an element of risk and a dose of courage. Trust in a caring relationship is not being

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indiscriminate, either in one's own or in another's capacity and judgment.

*Humility* is present in the caring process in several ways. It involves continuous learning and an awareness of the uniqueness of each new situation regardless of how extensive one's previous experience has been. It includes an acceptance of dependence and an awareness of personal limitations.

*Hope,* as an expression of a present alive with possibilities and plenitude, is not to be confused with wishful thinking and unfounded expectations. Hope implies that there is or could be something that is worthy of commitment and that mitigates against despair.

*Courage* makes risk taking possible, which carries one beyond safety and security. But it is not blind. It is a courage informed by knowledge, by past experiences and by a trust in one's own and in another's ability to grow.[11]

Others have described caring in terms of commitment; a way of life which finds expression in the "therapeutic use of the self."[12] The committed, Clemence said, is one who accepts full responsibility for one's action and is willing to take risks, to face danger, to be a "witness" to life. Those who refuse commitment by becoming detached, calloused and cynical are "spectators" to life rather than "witnesses."[12] Commitment and a therapeutic use of self is not, she warns, to "be advised heedlessly, nor claimed lightly . . . [they] . . . can be achieved only at the cost of anxiety and suffering."[12(p505)] Commitment, as an ingredient of caring, Levine said, is "the willingness to enter with the patient that predicament which he cannot face alone as an expression of moral responsibility; the quality of the moral commitment is a measure of the nurse's excellence."[13(p845)]

"Therapeutic use of self" is what I have described elsewhere as the component of personal knowledge.[14] It requires what may be referred to as the sacrifice of form; the awareness that abstract and generalized categories describing common group behaviors and traits can never encompass or express the uniqueness of the individual. The perception of a patient as a person goes beyond categorical recognition; it involves an active gathering of details and scattered particulars into an experienced whole for the purpose of seeing what is there. It is this kind of perception that results in a unity between an action taken and results.

### *Key Issues Related to Caring*

Specialization and the impact of science and technology have been identified as two major influences affecting the process and the act of caring within the health care system. These factors can further be associated with a few key issues which seem more closely identified with any discussion of the ethics of caring:

1. the nature of the health care provider-patient relationship;

2. informed consent;
3. determination of the quality of life; and
4. determination of ethical participation in decision-making.

These key issues will be discussed together.

Any relation between two people or groups carries with it a set of mutual expectations. Obviously, the relationship between the health professional and the patient or client entails several unique features that other human relationships do not share. The exact nature of these features is not always clear nor agreed upon by different authorities. However, few would disagree that specialization within the health care system, the team approach and the specialization of health care providers have irretrievably altered the environmental context in which these human relationships occur.

Veatch has identified and characterized several idealized models of the physician-patient relationship.[15] Starting with Veatch's basic characterizations, these models can be expanded to include all professional health care provider-client relationships.

## THE ENGINEERING MODEL

In the "engineering model" the health professional assumes the rhetoric and guise of the popularly conceived image of the scientist. He deals only with facts, divorcing himself from all questions of ethics and value considerations in the decision-making process. The health care provider's role in this model is to completely and dispassionately present the facts to the patient, let the patient decide and then proceed to carry out those decisions.

This approach, at first glance, would seem to maximize the participation of the patient in the decision-making process and to more than satisfy the essential ingredient of honesty in the caring process. On closer inspection, however, the "engineering" approach to human relationships is logically impossible and ethically outrageous.[15] It is impossible to be value-free in situations where choices must be made daily which affect the quality of life. Each decision requires a value judgment as to what is significant and what is right. This approach is morally irresponsible and reduces humans to objects of science and collapses the category of what *ought to be* to mean nothing more than *what is possible.*

This frightening image of the impartial application of science to health care is addressed in a moving and sensitive book entitled *A Very Easy Death* by the French author Simone de Beauvoir. The book is concerned with the examination of the day-by-day tragedy of her mother's death following the discovery of inoperable cancer of the intestines. The author, reflecting on the surgeons who were responsible for her mother's medical care, felt a liking for Dr. P because he talked to her mother "as though she were a human being and he answered my questions willingly."[16(p61)] On the other hand, she and her sister did not get along with Dr. N at all. Dr. N was "infatuated with technique, and he had resuscitated maman with great zeal; but for him she was the subject of an interesting experiment and not a person. He frightened us."[16]

### THE PRIESTLY MODEL

The "priestly model" characterizes the health professional in the other extreme. The role assumed here is frankly paternalistic; it removes the locus of decision making from the patient and places it in the hands of the health care professional. According to Veatch, the chief diagnostic sign of this approach is the "speaking-as-a" syndrome. "The problem," he said, "is one of generalization of expertise: transferring of expertise in the technical aspects of a subject to expertise in moral advice."[15(p6)]

The "priestly" health care provider is presumed to have competence in both areas by virtue of his specialized knowledge and experience. There is no apparent awareness of the need for humility and no indication of trust or confidence in the other. There is, in addition, another more subtle dimension to this model which enlarges the moral questions: the failure to appreciate one of the essential requirements of caring, the alternating rhythm of moving back and forth between the narrower ethical framework of the particular professional group and the broader set of societal ethical norms. "That there exists a wide chasm between the value systems of society and of the professional practitioner seems inherent in the conflicts that characterize issues of health care delivery,"[17(p63)] Levine observed. The scope and power of medical science which has grown with increasing knowledge is not sufficient reason to justify the vestment of authority about what constitutes "harm" and "good" in any particular group of individuals. Pellegrino reminds us that "In a matter so personal as health, the imposition of one person's values over another's . . . is a moral injustice."[1(p1293)]

### THE CONTRACTUAL MODEL

The "contractual model" is a nonlegalistic agreement between the professional and the client regarding general obligations and expected benefits for both parties. The basic obligations are governed by the norms of individual freedom, such as preservation of individual dignity, insofar as choice and control over one's body and quality of life contributes to that dignity. Honesty is an inherent requirement in terms of truth telling and promise keeping to make possible a truly informed, voluntary consent. There is a mutual trust even though it is recognized that there may not be a complete mutuality of value sharing. There is an acknowledgement by the patient that the professional practitioner has the requisite skill to make the technical decisions. There is an acknowledgement by the professional practitioner that technical decisions are governed by a prior shared decision-making process that respects each party's moral integrity. Undoubtedly, this is an idealized model that obviously very few health care professional-client relationships conform to. However, if there is at least an attempt to aim at this ideal model, patients would have available to them the best science and technology that can be employed in their behalf in a "caring" relationship.

## LEARNING TO BE MORE HUMANE

How then can we as health care professionals learn to be more humane and

authentically caring? Some have advocated a greater emphasis on the social sciences and the humanities within the formal professional educational experience. Currently there are several professional schools attempting to integrate humanistic studies into the more traditionally conceived formal professional curricula.[18] Certainly study in those disciplines which provide us with a broader and more representative understanding of the factual and imaginative dimensions of the human condition is of benefit. The error in this approach, Clouser said, is to expect that a study of the humanities will make a person more humane.[19]

The study of the humanities within the context of a professional program, however, does offer a unique opportunity to utilize the readily available experiential data which center on personal involvement of the practitioner with the specific concerns of the patient. The possibility of the cultivation of the imagination and of compassion in dealing with patients, that is, the coming to know the uniqueness of the individual, is enhanced through empathic acquaintance.[20,21]

A complete awareness of the meaning of another's life experience is never possible. But empathic understanding can extend our range of imagined possibilities. Empathy may be defined as the capacity for participating in or vicariously experiencing another's feelings. It requires one to imaginatively take the role of another in order to understand and accurately predict that person's thoughts, feelings and actions.

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Empathy is moderated by detachment in order to apprehend and abstract what one is attending to, and in this sense is objective.[14] It is an affective attribute in much the same way as Pellegrino describes compassion in that it is reflected in a genuine capacity to feel and "to share in the pain and anguish . . . an . . . understanding of what sickness means to another person, together with a readiness to help and to see the situation as the patient does."[1(p1289)] Empathy is not what is commonly understood as pity or sympathy, nor should it be confused with condescension or paternalism. The empathic person is able to perceive multiple possibilities of meaning simultaneously and has the capacity to "listen to feelings and moods, to nonverbal behavior, as well as to words."[22(p13)]

Caring is not readily, if at all, learned in a classroom or a formal course of study. Some acquaintance with the social sciences and the humanities may contribute to our understanding of the real and imaginative dimensions of human existence. But it will not necessarily result in a caring attitude. To be humane, sensitive and caring practitioners, we must believe in the dignity and worth of the person, and we must understand firmly the meaning of values, choices and priority systems within which values are expressed.[1] We need especially to critically examine our own personal value systems and to identify "specific clinical situations in which value

questions influence the outcome for human beings seeking help."[1(p1293)]

For those of us who profess to "care" for those we serve it should be agreed that "the wholeness which is part of our awareness of ourselves is shared best with others when no act diminishes another person, and no moment of indifference leaves him with less of himself."[13(p849)]

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