Part I

Healthcare Ethics: Multidisciplinary Approaches

Introduction

The main aim of the first part of this book is to illustrate, through the work of a selection of key authors, the wide range of philosophical traditions relevant to healthcare ethics.

The distinctive feature of healthcare ethics, as we defined it in the volume Introduction, is that it makes central the diversity of human values operative in all areas of healthcare policy and practice. The dominant model within bioethics, at least in its interaction with practice, has been quasi-legal. Within quasi-legal ethics, as we described, philosophical reasoning is used primarily to give effect to particular values, such as autonomy of patient choice. The chapters in this first part of the book illustrate the extent of the reaction within bioethics against the quasi-legal model. Each shows in different ways, and to different degrees, the wide variety of philosophical approaches available for giving effect to the many voices at the heart of healthcare ethics.

As illustrations of these philosophical approaches, each chapter largely speaks for itself. Susan Sherwin (ch. 1) and Morwenna Griffiths (ch. 5) draw on feminist traditions to argue for a shift from individualism to a more relationship- or community-based ethic. Michael Parker (ch. 2) and Guy Widdershoven (ch. 4), while recognizing the dangers of individualism, note the equal and opposite threat (to the diversity of human values) from communitarianism: they offer, respectively, discursive and hermeneutic approaches to squaring the circle here. S. Kay Toombs (ch. 3) is a phenomenologist: she shows, through her account of her experiences as a multiple sclerosis sufferer, the extraordinary power of phenomenology to illuminate the experience of illness. Gwen Adshead (ch. 6), although consciously echoing the title of Carol Gilligan's foundational book on feminist ethics, *In a Different Voice* (1993), demonstrates with three cases from forensic psychiatry the limitations of relationship ethics.

The remaining chapters in this section illustrate the contributions to healthcare ethics of three more traditional philosophical approaches: linguistic analysis – Peter Allmark's sharp dissection of the concept of "care ethics" (ch. 7); literary discourse analysis – Tod Chambers's worked examples of the use of the narrative features of case histories to reveal the perspective, or point of view, of the narrator (ch. 8); and comparative scholarship in the history of ideas – Charles Taylor's authoritative demolition of the acultural (perspective-free) view of modernity (ch. 9).

Taken together, these chapters illustrate and indeed develop a number of the key themes of healthcare ethics outlined in our main Introduction. Besides the central point about diversity of values (noted explicitly by both Parker and Widdershoven, for example), these themes include the importance of partnership (Widdershoven's notion of Gadamerian dialogue as the basis of the doctor–patient relationship); the ethical significance of diagnosis (Adshead's identification of the difficulties presented for relationship ethics by psychiatric conditions, such as personality disorders, the very nature of which consists in relationship difficulties); the need for a full-field or fact+value conceptual model of medicine (Taylor's account of the "symbiotic relationship" between science and culture, culture being understood as "a constellation of understandings of person, nature, society, and the good"; and the substantive role of communication skills (in Parker's "discursive negotiation of meaning", and in Toombs's account of the unique individual present in "symptoms, diagnosis, and therapy").

A further key theme, which at first glance might seem to be inconsistent with the main thrust of this book, is the importance of quasi-legal ethics. In urging the need for healthcare ethics, we may at times have appeared to make quasi-legal ethics the villain of the piece. But quasi-legal ethics, as we emphasized at the start of our main Introduction, has a number of important roles.

One such role is to empower disadvantaged groups. Thus Sherwin, who is concerned to break the power of healthcare institutions "deeply implicated in the maintenance of structures of oppression" and thus to foster the agency of patients and non-professionals, argues that these ends will be achieved not by abandoning but by supplementing the principles approach. Griffiths, similarly, reconstructs the notion of autonomy, rather than rejecting it altogether. Like many feminist writers, she questions the lived experience of autonomy for women; yet she also finds it an essential component of women's liberation. Adshead, too, writing of what is arguably the most oppressed group of patients – those with mental disorders – argues that principles, although not in themselves sufficient, are nonetheless a necessary protection against abuses of the therapeutic relationship.

Our selection of philosophical approaches relevant to healthcare ethics is, of course, far from complete. This is a rapidly growing area with a number of significant recent publications (see, for example, Steven Sabat's (2001) application of discourse analysis to problems of meaning in old-age psychiatry). But we hope that our selection illustrates the range and power of the methods available for making healthcare ethics, with its focus on the diversity of human values, an equal partner with the dominant quasi-legal model in meeting the challenges of twenty-first-century healthcare.

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1

Toward a Feminist Ethics of Health Care

SUSAN SHERWIN

The Role of Context

Biomedical ethics, like feminist ethics, is a new, rapidly developing area of philosophic specialization. It, too, is committed to developing analyses that can offer meaningful guidance in the morally troubling situations of real life, and it shares with feminist ethics a sense of frustration with the level of abstraction and generality that characterizes most traditional philosophic work on ethics. Writers in both fields are critical of the limitations that are created when we restrict ethical analysis to the level of general principles; both perceive a need to focus on the contextual details of actual situations that morally concerned persons find problematic. The use of context is quite different in the two fields, however, and in this chapter I shall examine this difference, so that we can see what is needed to develop a feminist ethics of health care. Looking at the gaps in nonfeminist bioethics, we can see that a contextually based moral theory must maintain a level of generality that supports an analysis of gender-based power relations in its evaluations.

[Elsewhere] I have reviewed some ways in which feminists have been influenced by Carol Gilligan's (1982) claim that women are more likely than men to understand morality as consisting of caring for others and men are more likely than women to understand morality as a system of abstract, universal rules. Although intrigued by the empirical evidence of an existing gender difference in moral reasoning, many feminists remain uneasy about the normative significance of this gendered description of ethics and are unwilling to endorse an unqualified commitment to caring as a moral ideal.

In interpreting her research data, Gilligan also identifies a methodological difference in women's and men's distinctive patterns of moral reasoning. She finds that girls and women tend to evaluate ethical dilemmas in a contextualized, narrative way, looking at the particular details of a problem situation when making ethical decisions; in contrast, boys and men seem inclined to apply a general, abstract principle to the situation without paying specific attention to the unique circumstances of the case. Several feminists have found this difference in method to be a promising basis for building feminist ethics. Although still cautious of the implications of gender-specific patterns of moral reasoning, most feminists endorse including context as a central element in moral reasoning.

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I believe, however, feminist ethicists must be more precise about the term "context." Although mainstream medical ethics also expresses a commitment to contextual ethics, it is by no means a form of feminist ethics. In reviewing the differences between feminist ethics and medical ethics, the importance of clarifying the contextual details relevant to a distinctively feminist ethical analysis will become apparent.

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Further Areas of Similarity Between Feminist and Medical Ethics

There is substantial agreement between those who pursue feminist and medical ethics on the importance of certain kinds of contextual features. Both recognize that an ethics of actions must be supplemented by discussion of the nature of the relationships that hold between the agents performing an action and those who are affected by it. Both feminists and medical ethicists are critical of the traditional assumption – made most explicitly by contractarians but also often assumed by other sorts of theorists – that the role of ethics is to clarify the obligations that hold among individuals who are viewed as paradigmatically equal, independent, rational, and autonomous.

Feminist ethicists accept the arguments offered within the realm of "feminine" ethics, which demand that attention be paid to the interdependent, emotionally varied, unequal relationships that shape human lives. Similar claims are found in the literature of medical ethics, where it is widely recognized that the relationships that exist between physicians and their patients are far from equal (especially if the patient is very ill) and that the model of contracts negotiated by independent, rational agents does not provide a useful perspective for this sort of interaction. In particular, the disadvantaged position of the dependent patient is a major theme in the many discussions of paternalism that are found throughout the medical ethics literature. Further, many authors are sensitive to the fact that the physician–patient relationship is not a dyad that exists in some abstract, eternal realm; it is found within overlapping networks of other relationships, which bind patients and physicians to their respective family members, other health professionals, neighbors, employers, health services administrators, and so on (for example, Hardwig 1990).

In addition, we can find parallel claims in the literatures of feminist and medical ethics of the importance of evaluating behavior in terms of its effect on the quality of relationships among persons concerned. For instance, discussions in medical ethics on the importance of telling patients the truth about their condition often refer to the effect that a discovered lie would have on the physician–patient relationship; it is frequently claimed that patients who learn that their physicians have deliberately deceived them are likely to feel especially betrayed by the violation of trust in light of their feelings of vulnerability and dependency, despite the supposedly benevolent motives that might have contributed to the deceptive behavior. Feminist theorists, for their part, note that ethics should not only be concerned with actions and relationships but also focus on questions of character and the development of attitudes of trust – and antitrust – within those relationships (see Baier 1986). For example, Sarah Hoagland (1988), Marilyn Friedman (1989), and Iris Marion Young (1989) all focus on the conditions necessary for the building of (feminist) community.

Moreover, as in feminist ethics, discussion in medical ethics often raises considerations of caring; this requirement is usually couched in the language of beneficence – an attitude that is generally assumed to be owed to patients. Medical dilemmas are sometimes discussed in terms that appear to rank sensitivity and caring ahead of applications of principle; compassion is frequently claimed to be more compelling than honesty or justice.

There seems, then, to be agreement between the two fields on a variety of concerns regarding traditional moral theory. Authors in both disciplines argue that matters of character, responsibility, and other features that affect trust are morally significant. Both reject the oversimplifying tendency of normative theorists to reduce

all moral considerations to short sets of universal principles. Given their shared commitment to focusing on context in moral problem-solving, their common understanding of the ethical significance of inequality within relationships, and the tendency of some authors in both traditions to include caring values in their analyses, it might appear that medical ethics is already well on its way to being feminist. Medical ethics, however, does not display any commitment to ending oppression; thus most of the writings of contemporary medical ethics must be judged as lacking from the perspective of feminist ethics.

Feminist ethics requires that any evaluation of moral considerations attend to the power relations that structure the relevant interactions. Political analyses of the unequal power of women and men, of white people and people of color, of First World and Third World people, of the rich and the poor, of the healthy and the disabled, and so forth are central to feminist ethics. To date, that sort of analysis has been almost entirely absent from the literature of mainstream medical ethics, although the institutions in which health care is provided are deeply implicated in the maintenance of structures of oppression.

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Other Features of a Feminist Ethics of Health Care

There are numerous other ways in which work in feminist ethics can inform and transform work in medical ethics and in which medical ethics can provide models (both good and bad) for work in feminist ethics. For instance, the literature in both feminist and medical ethics reflects an interest in questions concerning the nature and quality of particular relationships, because both feminist and medical ethicists recognize that rights and responsibilities depend upon the roles and relationships that exist among persons of differing power and status. New models of interaction within the area of health care are needed to develop a system of care that is less hierarchically structured and less focused on matters of power and control than the current institutions. Feminist explorations of friendship (Code 1987) or mother–child (Held 1987a) relationships are worth pursuing as a basis of alternative models for these institutions.

A feminist ethics of health care will have other distinctive dimensions that mark its departure from the familiar mainstream approaches to medical ethics. For example, it demonstrates how the role of the patient is perceived as feminine. Patients are required to submit to medical authority and respond with gratitude for attention offered. Most recognize their vulnerability to medical power and learn the value of offering a cheerful disposition in the face of extraordinary suffering, because complaints are often met with hostility and impatience. Like those who are socially defined as subservient, patients often find themselves apologizing for the inconvenience of needing attention; most know their obligation to listen submissively to medical direction. Because feminism is occupied with redefining feminine roles, a feminist ethics of health care takes a natural interest in redefining the feminine aspects of the role of patient.

For this reason, a feminist ethics of health care includes reflection on the underlying medical views of the body. Medical practice involves the explorative study, manipulation, and modification of the body; because, under patriarchal ideology, the body is characteristically associated with the feminine, the female body is particularly subject to medical dominance. Its practitioners presume the license to probe the body for its secrets, as well as the authority to define its norms and deviations. As the contributors to *Body/Politics: Women and the Discourses of Science* (Jacobus, Keller, and Shuttleworth 1990) make clear, there are significant political and moral questions to be explored regarding the relations between medicine and the feminine body. The discourses common to medicine and science both reflect and support attitudes about the body that reinforce patriarchal forces.

Further, as Esther Frances (1990) proposes, a feminist ethics of health care should evaluate the significance of challenges to allopathic medicine with respect to the oppression of women. There are numerous critiques of the

assumptions and practices of allopathic medicine and many competing visions of alternative health care practices. Many women have found some of these alternatives attractive; some seem to promise a more empowering, less hierarchical understanding of health than is found in mainstream allopathic medicine. In a feminist ethics of health care these various approaches should be explored and examined with regard to their promise for relieving some of the harms women now experience under sexism.

Like other projects in feminist ethics, a feminist ethics of health care is concerned with going beyond analysis of how women have been systematically oppressed by patriarchy; it seeks to foster agency where agency has previously been restricted by patriarchal patterns and assumptions. The agenda of traditional bioethics has been largely occupied with questions about the responsibilities of health professionals; the agenda of a feminist ethics of health care is significantly farther-reaching. It is directed also at exploring the various roles that may be open to patients and nonprofessionals in the pursuit of health and health policy. It is not sufficient to put specific moral restrictions on the behavior of health-care providers; we must also ensure that the health care delivery system is modified in appropriate ways to allow consumers to achieve their ends with respect to their own health.

A principal task of a feminist ethics of health care is to develop conceptual models for restructuring the power associated with healing, by distributing the specialized knowledge on health matters in ways that allow persons maximum control over their own health. It is important to clarify how excessive dependence can be reduced, how caring can be offered without paternalism, and how health services can be obtained within a context worthy of trust. Feminists seek to spread health information widely and foster self-help approaches to health matters. Feminist values imply that medical expertise should be viewed as a social resource, and as such, it should be held under the control of patients and their caregivers. A feminist ethics of health care suggests that the institution of medicine should be transformed from one principally occupied with crisis management to one primarily committed to fostering health empowerment. We must, then, look at the existing structures of medicine and medical interaction when attempting to understand the details of any particular medical experience.

I have spelled out some important features of what I envision as a feminist ethics of health care, but this is not an exhaustive description. This book represents an initial step in the task of developing such an ethics, but much more work remains to be done. Others will add further dimensions. The common agenda of work characterized by the label "feminist ethics of health care" will be to provide a more comprehensive and fairer approach to medical ethics than has been evident in the literature to date.

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