

ethics of **JUSTICE** vs the ethics of **CARE** in **MORAL DECISION MAKING**

Annatjie Botes

Professor: Department of Nursing
Rand Afrikaans University

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*Philosophical
Discourse*

Abstract

The question to be addressed in this paper is : How can the ethics of justice and the ethics of care be used complementary to each other in ethical decision making within the health care team? Various arguments are presented that justify the reasons that the ethics of justice and the ethics of care should be used complementary to each other for effective ethical decision making within the health care team. The objective is to explore and describe the compatibility of the ethics of justice and the ethics of care from two perspectives: firstly an analysis of the characteristics of the two ethical theories, and secondly the scientific-philosophical viewpoints of these theories. The two theories are incompatible when viewed from these perspectives. For a probable solution to this incompatibility arguments are presented from the perspectives of reflection and virtue-based ethics.

Opsomming

Die vraag wat in hierdie referaat aangespreek word is: Hoe kan die etiek van geregtigheid en die etiek van omgee komplementêr tot mekaar gebruik word in etiese besluitneming in die gesondheidspan. Verskeie argumente word aangebied waarom die etiek van geregtigheid en die etiek van omgee komplementêr tot mekaar gebruik behoort te word vir effektiewe etiese besluitneming in die gesondheidspan. Die doelstelling is om die versoenbaarheid van die etiek van geregtigheid en die etiek van omgee vanuit twee perspektiewe te verken en te beskryf: eerstens, 'n analise van die kenmerke en tweedens die wetenskapsfilosofiese vertrekpunte van die twee etiese teorieë. Hiervolgens is die twee etiese teorieë onversoenbaar. As moontlike oplossing vir die onversoenbaarheid word argumente vanuit deugde-etiek en refleksie aangebied.

INTRODUCTION

As background to this paper which deals with the complementary use of the ethics of justice and the ethics of care in ethical decision making within the health team, the following case study from research (Burger, 1996) is described, the object of which was to identify factors in decision making on life-supporting treatment.

Mrs C Du Toit is a 55 year-old married woman who resides in the country. Her husband is also 55 years old and a pensioner. They have four married independent children. Beth lives in the city while Ronel, Peter and Carin live in the same town as their parents.

In January, Mrs Du Toit was admitted to the local hospital with respiratory distress. She was eventually transferred to the intensive care unit of a hospital in the city. After spending 18 days in the intensive care unit she was discharged with a prescription for oral steroids.

She also suffered from chronic ulcerative colitis and received new medication for this condition which aggravated the symptoms of diarrhoea. She developed symptoms of an acute abdomen and was admitted to the local hospital once again, where a laparotomy for obstruction was performed.

As a result of infection and poor wound healing she was transferred once again to the intensive care unit of the city hospital on 12 September.

On 15 September, the radiological tests indicated perforation of the small intestine. An intestinal resection was performed the same day which revealed that the small intestine had not healed and that the abdomen was filled with faecal matter.

On 22 September she was taken to the operating theatre for abdominal irrigation. A tracheostomy was performed at the same time.

She progressed well initially and the mechanical ventilation rate was reduced to 2 per minute. She received maintenance infusions, antibiotics and a renal dosage of dopamine.

A Midazolam infusion was continued until 24 September and a morphine infusion until 26 September. She was fully conscious and orientated to time, place and person.

By 4 October she gradually became confused and lost consciousness. Communication with her was impossible from that day.

Her physical health deteriorated. Since 4 October she no longer passed urine and a diagnosis of renal failure, hepatic fail-

ure and respiratory failure as a result of sepsis was made.

Adrenaline infusions were also administered from 4 October. Dobutamine was resumed for a couple of hours on 8 and 9 October but from 10 October it was administered uninterruptedly.

Mr Du Toit was at his wife's bedside each day. He spent the nights with his daughter, Beth, who took him to the hospital every day. On 5 October, the possibility of withdrawing the treatment was discussed with Mr. Du Toit and Beth.

The medical practitioner, Dr Meyer, explained that he was of the opinion that further treatment such as dialysis would be of no use because she did not react to the present treatment. Dr Meyer would find out Mr Du Toit and Beth's decision after lunch.

After consulting with the other children, the family decided unanimously not to withdraw treatment. Various reasons were advanced by the family for this decision. Among others, they felt that she was very ill the last time and that she had recovered.

Ronel believed that it would boil down to murder and this was unacceptable to her. The family felt that they did not possess the necessary knowledge for such a decision and to them it was unthinkable to expect it of them.

They believed that God alone could decide about life and death. The family also considered the possible wishes of Mrs Du Toit in their decision.

Mrs Du Toit's blood pressure improved to such an extent that afternoon that Dr Meyer decided to continue the full treatment. She had received haemodialysis since 6 October.

Dr Meyer was of the opinion that a lot of uncertainty existed about sepsis and that one therefore had to be careful. There was no guarantee that any decision would be the right one.

The unit manager, Mary, disagreed with the decision. She was of the opinion that it was not fair to give the family false hope nor to mislead the family.

The fact that positive inotrope therapy had already been withdrawn strengthened her belief.

Furthermore, Mary believed that the situation was not fair to the nursing staff who felt uncomfortable about the doctors' lack of agreement.

The involvement of the nursing staff with the patient and family made it difficult for them not to bring their emotions into the decision making.

Elsa, a nurse who had been involved in

Mrs Du Toit's care for a considerable time, decided to talk to the family about the possibility of withdrawal. Elsa was of the opinion that Mrs Du Toit only had a 5% chance on recovery because she had multi-organ failure and did not respond to treatment.

Mrs Du Toit was getting thinner by the day. Elsa said that she could not stand seeing the family suffer like that any longer. Elsa expressed concern about the enormous medical costs for which the family were responsible and she thought it was absurd to pay for treatment to which Mrs Du Toit did not respond.

The family, however, was very upset after their conversation with Elsa. They believed that the nurses were too used to death and that they did not care.

On 16 October, the possibility of withdrawal of treatment was discussed once again by the medical team. Dr Meyer was of the opinion that Mrs du Toit had no prognosis as a result of the multi-organ failure and the sepsis and that further treatment would be useless at that stage.

Dr Meyer decided not to talk to the family about the decision. He did not want to make them feel guilty. Treatment was gradually withdrawn and Mrs Du Toit died the next evening.

Following on, and complementary to the case study are the following relevant aspects for the problem statement of this paper.

PROBLEM STATEMENT

Many changes have taken place in health care ethics (Loewy, 1996:vii). These changes go beyond international borders.

Firstly, the doctor is no longer the only role player in ethical decision making in health care. The role of other members of the health team, such as the nurse in ethical decision making, is becoming greater (Loewy, 1996:vii).

All the members of the professional health team are independent practitioners who are responsible and accountable for their own actions and omissions (compare legislation of the different disciplines in the health team).

Therefore it is not reasonable for the doctor to make ethical decisions independently of the other team members. This viewpoint is also supported by Loewy (1996:viii) who, for this reason, has changed the title of his book from *medical ethics* to *health care ethics*. In the case study the conflict was evident when the doctors alone made the decisions.

Secondly, it appears from the case study that the ethical decision making of doc-

tors and nurses is based on divergent and opposing ethical theories.

The doctors in this case study based their ethical decision making exclusively on the physical health status of the patient. The way in which the doctors made the ethical decisions corresponds with the ethics of justice of Kohlberg (1981). This moral orientation is probably related to the positivist paradigm (modern scientific view) which dominates medical education and research.

The way in which the nurses made ethical decisions was based on their involvement in and experience of the total needs of the patient and the family.

Apart from the physical health status of the patient, the nurses also considered other factors in their ethical decision making which corresponds with the ethics of care of Gilligan (1982).

This ethical orientation can probably be attributed to a holistic and caring approach on which education and research in nursing is moulded.

Thirdly, there are two sides to cultural activities and ethical phenomena in society (Rossouw, 1993:92).

On the one hand, moral phenomena refer to the life world which consists of physical aspects such as available resources and personnel. On the other hand, moral phenomena refer to life ethos which deals with what is of value and meaningful to people.

Scientific practice is also a type of cultural activity. In the history of scientific practice two different knowledge ideals in particular are present.

The modern knowledge ideal, which Rossouw (1993:99) calls knowledge as power, is directed at the life world. The knowledge ideal which Rossouw (1993:98) calls knowledge as virtue and Maxwell (1984) calls wisdom, is directed at the life ethos.

The ethics of justice relates to the modern knowledge ideal, namely knowledge as power, while the ethics of care relates to knowledge as virtue.

To accommodate all aspects of moral phenomena both knowledge ideals are necessary. Rossouw (1993) and Maxwell (1984) are of the opinion that if only the knowledge ideal of power applies and is not balanced by knowledge as virtue, it could and has had disastrous consequences for society.

The ethics of justice as well as the ethics of care should be implemented to address all ethical aspects of health as a social phenomenon.

Fourthly, the health care consumer makes demands on health services which are

based on a holistic and caring attitude (Phillips & Brenner, 1994:vii).

There is dissatisfaction world-wide about a materialistic, deterministic world view (Thomasma, 1994:123).

Today, ethics is a matter of public interest (World Health Organisation, 1996). An approach based on justice therefore does not meet all the requirements of the health care consumer.

It appears that the ethics of care should be added to the ethics of justice, on the one hand to meet the demands and needs of the health care consumer and, on the other hand, to address the life world as well as the life ethos of ethical phenomena.

From the case study it appears that these divergent, opposing perspectives in ethical decision making within the health team could complicate ethical decision making in health care practice. This could give rise to unnecessarily prolonged physical and mental suffering, conflict and financial complications.

From this problem statement it appears that the following question is important, namely:

How can the ethics of justice and the ethics of care be used complementary to each other in ethical decision making within the health team?

OBJECTIVES OF THE PAPER

The first objective of the paper is to explore and describe the reconcilability/ irreconcilability of the ethics of justice with the ethics of care.

The nature and reconcilability/irreconcilability of the ethics of justice and the ethics of care are explored and described from two perspectives: firstly from an analysis of the distinctive characteristics of the two ethical approaches, and secondly from the scientific-philosophical perspective of the two ethical approaches.

The second objective of the paper is to describe the operationalisation of the ethics of justice and the ethics of care as they complement each other in ethical decision making within the health team.

CHARACTERISTICS OF THE ETHICS OF CARE

The following table reflects the characteristics of the ethics of care.

Table 1:

The characteristics of the ethics of care

Care and love for oneself and for others
Holistic perspective on moral phenomena
Responsibility towards each other
Relationship of moral phenomena
Maintenance of harmony and relations
Sympathetic
Linked to emotion and feeling
Dedication
Involvement of moral agent
Focus on the needs of others
Empathy
Caring as a virtue
Inductive thinking skills: Focus on the realities of specific ethical situations rather than principles and rules
Respect for others
Understanding human dignity
Mutual trust
Commitment
Conscious-linked and internal locus of control
Uniqueness of every moral situation
Autonomy of agents
Bound to knowledge and skills
Hope
Courage
Modesty
Patience
Active participation

The following model case reflects the characteristics of the ethics of care.

Dr Meyer and the Sister in Charge, Mary, feel very sorry for the Du Toit family. Mr Du Toit and Beth spend twelve to eighteen hours per day with Mrs Du Toit. Dr Meyer and Mary wonder how Beth's family is coping with the situation as she spends almost the entire day with her mother.

Although the Du Toit family implies that finance is no problem, the question of finance may, in fact, become a problem if Mrs du Toit spends more than a month in the intensive care unit.

The ethical decision about withdrawal of treatment is very difficult for Dr Meyer and Sister Mary in view of the reaction of the family after the matter had been dis-

cussed with them. They feel very guilty about involving the family in the decision particularly as the family regarded it as unfair and felt that they did not possess the required knowledge to make such a decision. Mary and Dr Meyer feel that they are causing the family more stress.

Elsa, in whose care Mrs Du Toit has been entrusted, fulfils her responsibility towards Mrs Du Toit in an efficient manner. She carefully administers the medication as prescribed. She provides care for Mrs Du Toit's basic needs in a special, dedicated way. Elsa feels that she would want her own mother to be cared for with the same respect and dignity.

She experiences inner satisfaction caring for Mrs Du Toit. Elsa feels very sorry for Mr Du Toit and Beth who are so dedicated. She constantly offers them something to drink and provides information about Mrs Du Toit's treatment.

Dr Jackson spends time with the family and explains that Mrs Du Toit no longer responds to the treatment. He supports the family emotionally without giving them false hope. He explains the team's treatment strategy to the family and asks their opinion about it.

The doctors realise under what enormous pressure the nurses in the unit work and they often thank and compliment them. The nurses have a lot of respect and faith in the medical decisions because the doctors discuss these with the staff and explain their decisions.

The inputs and decisions of the nurses are also taken into consideration. This gives rise to harmony and commitment among all the team members. The team once again realises that every ethical situation is unique. It is very difficult for them to make a decision to stop treatment.

For this reason they continue with less drastic treatment. Their first priority is to respect Mrs du Toit's dignity and to relieve her suffering.

After Mrs Du Toit's death, the family express their gratitude to the team for their good medical and nursing care.

SCIENTIFIC-PHILOSOPHICAL BASIS OF THE ETHICS OF CARE

Firstly, the association between nursing as a discipline and the ethics of care is related to the dominant paradigm of care in the discipline. Recent nursing literature, in particular, shows a strong tendency towards this paradigm (Crowden, 1994:1140; Ray, 1994:'05). Benner (1994:42) regards caring as a *way of knowing*.

From a phenomenological perspective

caring is the most basic form of being and is central to all health professions (Benner, 1994:44). *In health care, caring sets up the possibility of cure* (Benner, 1994:44). In health care, science and practice would lose their ethical and epistemological perspective without the ethics of care.

Secondly, the approach of Kohlberg is one-sided since women were excluded from the empirical observations. In protest to this the initial works of Gilligan show an empirical feminist perspective.

The ethics appears to be of care but is not connected to two perspectives of feminism (Harding, 1991:vii), namely the feminist view which constructs knowledge from a female perspective and the feminist perspective which opposes the Enlightenment perspective.

The later works of Gilligan are, however, more interpretative and empirical than feminist.

Thirdly, this publication of Gilligan gave rise to debates which lasted well into the nineties. These debates are related to the change in perspectives in the philosophy of science. The change which took place was from modernism, enlightenment epistemology to post-modernism (Hekman, 1995:2).

On the one hand, it appears that Gilligan supports the epistemology of modernism while, on the other hand, it appears that she is directly opposed to it (Hekman, 1995:26). As long as the modernistic view is taken as the only form of rationality, the view will be held that the ethics of care is subordinate and less rational than the ethics of justice.

The problem is, therefore, methodological since it concerns the nature of rationality.

As far as Gilligan is concerned, the ethics of justice is based on value-free, objective and neutral perspectives while the ethics of care is based on understanding and comprehension of the narrative of social relations (Hekman, 1995:17).

The moral domain is therefore of a contextual and personal nature to Gilligan, who hereby commits herself to a dialectic moral theory and a post-modern scientific approach (Hekman, 1995:17).

The decisions within the ethics of justice are made according to concrete ethical principles and rules without considering the unique characteristics of the specific situation.

In contrast with this, the ethics of care allows the feelings of the role players in the situation to direct the decisions. For this reason the ethics of care is not associated with rational decision making (Loewy, 1996:31).

CHARACTERISTICS OF THE ETHICS OF JUSTICE

The following table reflects the characteristics of the ethics of justice.

Table 2:

Characteristics of the ethics of justice

Justice
Rational decision making
Universal principles and rules
Consistency
Respect for the rights of man
Equality
Impartiality
Accountability for decisions
Obligations according to rules
Autonomy and self-determination
Uninvolvement

The following model case reflects the characteristics of the ethics of justice.

The personnel in the unit are irritated with Mrs Du Toit's visitors. They hamper them in the performance of their duties. They also feel very uncomfortable with the emotional outbursts of the family since they influence their objective judgement about the patient's treatment.

Dr Meyer deals with the family's enquiries about the patient's prognosis in an impartial manner and avoids emotional interaction. He believes that he is not responsible for their emotional support and he also feels uncomfortable with it. He thus gives them false hope to avoid any emotional reaction. The family is satisfied with his judgements since he tells them what they want to hear.

Dr Meyer communicates in the corridors with the family on the prognosis of the patient. He informs them that Mrs Du Toit is not responding to treatment and that she has multi-organ failure. There is, therefore, no sense in continuing with the treatment. Although he had already decided to withdraw treatment, he requests them to inform him of their decision after lunch.

Dr Meyer's decision is based on the poor prognosis of the patient and the availability of beds in the unit. Research has shown that the patients who do not respond to the prescribed treatment and who are in multi-organ failure have a very poor prognosis. In his opinion it is not fair to the patient, family or other poten-

tial patients to continue with the intensive treatment and care. A young patient who was injured in a car accident had to be taken to another hospital the previous night because there was no bed available in this unit.

Dr Meyer stops all intravenous medication and instructs the nursing staff to maintain and colour the infusion lines so that the family would not notice that the treatment had been stopped. Dr Meyer believes that it is fair not to let them know.

Mary and Elsa, as well as the other nursing staff, are angry and frustrated. The doctors make decisions without discussing them with the nurses. This complicates their task since they do not always agree with the decisions.

Elsa is of the opinion that the doctor made the wrong decision and she refuses to stop the treatment. She informs the doctor of her decision. Dr Meyer reports Elsa to the management of the hospital since he believes that she is acting outside her scope of practice. The relations between the nursing staff and the doctors is hostile and aloof. Although Mrs Du Toit is taken care of very well, the family feels that the caring and involvement of the staff are necessary.

SCIENTIFIC-PHILOSOPHICAL BASIS OF THE ETHICS OF JUSTICE

The ethics of justice with characteristics of objectivity, impartiality, universal rules and principles are probably connected with the modern scientific view of which logical positivism is the most important model.

This scientific model has dominated western cultural activities and nursing for decades. Maxwell calls the knowledge generated by this model knowledge as power. The success of this scientific model has been proved throughout the centuries. This knowledge has led to technological and scientific progress in western culture and societies.

Although the modern scientific approach resulted in progress, it also gave rise to disastrous consequences and suffering (Maxwell, 1984).

CONCLUSIONS REGARDING THE RECONCILABILITY OF THE ETHICS OF JUSTICE AND THE ETHICS OF CARE

From the characteristics and the scientific-philosophical points of departure of the ethics of justice and the ethics of care it can be stated that the two ethical per-

spectives are irreconcilable. This conclusion is supported by Hekman (1995:26) who states that Gilligan has not only added an additional dimension to existing moral theories, but that she has also established a completely irreconcilable theoretical void in moral theories. According to Hekman (1995:29) the epistemology of the ethics of justice and the ethics of care is irreconcilable.

This irreconcilability appears to be problematic since the ethics of justice and the ethics of care should be used complementary to each other for effective moral decision making.

The rationale for such a complementary use of the two perspectives is, firstly, the demand for holistic caring made by health care consumers on services and thus on moral decision making. Secondly, each perspective only addresses either the life world or life ethos facet of moral situations.

To address all the facets of moral situations it is necessary that the ethics of justice and the ethics of care are used complementary to each other. This one-sided vision of ethical problems is also indicated by the model cases of the two perspectives.

This brings us back to the question of the paper, namely:

How can the ethics of justice and the ethics of care be used complementary to each other in moral decision making within the health team?

THE COMPLEMENTARY USE OF THE ETHICS OF JUSTICE AND THE ETHICS OF CARE IN ETHICAL DECISION MAKING

The following arguments probably offer a solution to the problem of irreconcilability and the way in which the ethics of justice and the ethics of care can be used complementary to each other in ethical decision making in the health team.

For decades, the modern scientific view has been the dominating scientific approach in Western cultural history. The ethics of justice is connected to this model and for this reason probably to the dominant ethical theory.

The ethics of justice can be typified as a rule-orientated ethical theory. Rules are an inherent part of any society. Rules and

the domination of the modern scientific view and the ethics of justice cannot, therefore, be wished away.

Rules cannot, however, guarantee moral behaviour. Similarly, rules and principles cannot ensure that the decisions made on the basis of rules and principles are ethically correct. Something more than rules and principles is therefore necessary.

An ethics of virtues can probably offer the solution. Virtues are seen as inherent characteristics in a person. Ethics of virtues do not replace the rule-orientated ethical theories, but can rather be viewed as complementary to these theories since virtues facilitate better understanding and interpretation of rules and principles (MacIntyre, 1984; Macedo, 1992).

The characteristics of the ethics of justice, namely justice, fairness and respect for the rights of man can thus be regarded as virtues. Similarly, the following characteristics of the ethics of care can also be regarded as virtues, namely empathy, courage, dedication and responsibility. These virtues have all been described by Botes and Rossouw (1995) as virtues in nursing.

The perspectives of justice and caring therefore bring about specific virtues which facilitate better understanding and interpretation of the rules and principles. By way of discourse and negotiation people can use these virtues from a perspective of justice and care to interpret the rules and principles for each unique ethical situation. The strive with this discourse and negotiation is therefore consensus on ethical decisions.

Dissensus is also not excluded. Rossouw (1994:64) calls the process of rational interaction for moral sensitivity as a solution to moral dissensus. This implies that the members of the health team negotiate in a rational way to find the best possible moral solution.

Reflective thinking skills facilitate the rational management of aspects of the ethics of virtues as complementary to the ethics of justice. Without rationality the ethics of care has no right of existence within a scientific discipline such as health care.



BIBLIOGRAPHY

- BENNER, P 1994:** Caring as a way of knowing and not knowing. In PHILLIPS, SS &
- BRENNER, P 1994:** The crisis of care. Affirming and restoring caring practices in the helping professions. Washington: Georgetown University Press.
- BOTES, AC & ROSSOW, D 1995:** The reconstruction of virtue based ethics in nursing. *RAUCUR* 1(2). Nov.1995: 19-26.
- BURGER, G 1996:** Factors in decision making over life support therapy. (Masters Dissertation). Johannesburg: Rand Afrikaans University
- CROWDEN, A 1994:** On the moral nature of nursing practice. *Journal of Advanced Nursing* 20: 1104-1110.
- GILLIGAN, C 1982:** In a different voice: psychological theory and women's development. Cambridge: Harvard University Press.
- HARDING, S 1991:** Whose science? Whose knowledge? Milton Keynes: Open University Press.
- HEKMAN, SJ 1995:** Moral voices, moral selves. Cambridge: Polity Press.
- KOHLBERG, L 1981:** Essays in moral development. Vol.1: The philosophy of moral development. San Francisco:Harper & Row.
- KOHLBERG, L 1981:** Essays in moral development. Vol.2: The philosophy of moral development. San Francisco:Harper & Row.
- LOEWY, EH 1996:** Textbook of health care ethics. New York: Plenum Press.
- MACEDO, S 1992:** Liberal virtues. Oxford: Clarendon Press
- MACINTYRE, A 1984:** After virtue: A study in moral theory. Second edition. Indiana: University of Notre Dame Press.
- MAXWELL, N 1984:** From knowledge or wisdom. New York: Blackwell.
- PHILLIPS, SS & BRENNER, P 1994:** The crisis of care. Affirming and restoring caring practices in the helping professions. Washington: Georgetown University Press.
- RAY, MA 1994:** Communal moral experience as the starting point for research in health care ethics. *Nursing Outlook* 42 (3),May/June 1994: 104-109.
- ROSSOUW, HW 1993:** Universiteit, wetenskap en kultuur. Kaapstad: Tafelberg.
- ROSSOUW, D 1994:** Business ethics: A Southern African Perspective. Halfway House: Southern Book Publishers.
- THOMASMA, DC 1994:** Beyond the ethics of rightness: The role of compassion in moral responsibility.
- In **PHILLIPS, SS & BRENNER, P 1994:** The crisis of care. Affirming and restoring caring practices in the helping professions. Washington: Georgetown University Press.
- WORLD HEALTH ORGANIZATION 1996:** Volume 49 number September/ October 1996.