

Care and Its Pitfalls

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SUMMARY. A contemporary ethic of care is based on studies of the moral reasoning of women facing ethical dilemmas and on the experience of maternal nurturance. Because a care ethic stresses particular relationships rather than impartiality, it raises concerns about potential exploitation of caregivers, most of whom are women. While applicable to health care and pharmaceutical care, an ethic of care also raises questions regarding its theoretical justification and practical feasibility. This paper reviews the literature on care and its critics, and suggests possibilities for combining justice and care both theoretically and practically. [Article copies available from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworth.com]

INTRODUCTION

The concept and practice of care is familiar to all of us, and those who labor in the field of health care are particularly familiar with its practice. Throughout history, women have predominated as caregivers of the young, the ill, the aged, and the disabled, both in the informal setting of the home and in institutions (15). Although health care is not the only type of care that women render, it is central to their caregiving role.

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Why women predominate as caregivers is a question of interest, but not one that can adequately be answered here. Because of this predominance, however, it may be instructive to examine recent literature on care that has been written by women. Given the overall neglect of women in the history of philosophy, including the history of ethics, such an examination is likely to yield fruitful results, shedding light on the concept and practice of care by men as well as women (15).

As Warren Reich has shown in this volume, an ethic of care is not a new concept. Nonetheless, philosophers have seldom addressed its meaning or implications through close analysis or critique. One reason for the neglect is longstanding, widespread endorsement of a dichotomy between personal and public life: Care is typically seen as an appropriate model for interpersonal or private relations; the right to privacy is affirmed in this context. But care is not often viewed as an appropriate model for public interactions, where justice is the overriding principle. Nonetheless, Susan Moller Okin has argued persuasively that concerns about justice should extend beyond the "public" sphere of the market, the workplace, and politics to the "private" sphere of relationships among women, men, and children (18).

Philosophers of past and present have directed their attention to the requirements of universalizability and impartiality in ethical decision-making. In contrast, an ethic of care is concerned with the particularity and partiality of relationships. The public domain is essentially impersonal, while the private domain is personal or interpersonal. Accordingly, traditional philosophy has generally failed to explain, justify, or accommodate an ethic of care.

In what follows I consider the concept of care developed in the literature of moral psychology, and relate this to an ethic of care, health care, and pharmaceutical care. I then examine philosophical criticisms of an ethic of care, and conclude with a sketch of possibilities for combining care and justice both theoretically and practically.

A Contemporary Ethic of Care

The psychologists Lawrence Kohlberg and Carol Gilligan represent the contrast between traditional philosophical ethics and a con-

temporary ethic of care. Kohlberg proposed a model of moral reasoning based on stages of human development (12). In the first and second stages, decisions are intended to satisfy one's own needs or desires, such as avoiding punishment or obtaining rewards. In the third and fourth stages, decisions are based on the desire to live up to the expectations of others, whether the others be individuals or institutions such as the state or church. The fifth and sixth stages illustrate an abstract level of reasoning either through acceptance of the need to fulfill contractual agreements with others or through the acceptance of universal ethical principles such as justice and respect for the rights of individuals. Kohlberg related the later stages of moral development to the concepts of impartiality and universalizability that traditional philosophical ethics require of any moral theory. In his later writings, he referred to his model as one of "justice reasoning," acknowledging that other ethical models or principles may be utilized by individuals (13).

To develop his model, Kohlberg analyzed the answers to questions asked mainly of male subjects who were considering a hypothetical moral dilemma. The dilemma he used in some of his studies involves a pharmacist:

In Europe, a woman was near death from a special kind of cancer. There was one drug that the doctors thought might save her. It was a form of radium that a druggist in the same town had recently discovered. The drug was expensive to make, but the druggist was charging ten times what the drug cost him to make. He paid \$200 for the radium and charged \$2,000 for a small dose of the drug. The sick woman's husband, Heinz, went to everyone he knew to borrow the money, but he could only obtain about \$1,000. He told the druggist that his wife was dying and asked him to sell it cheaper or let him pay later. But the druggist said, "No, I discovered the drug and I have a right to make as much money as I can from it." Heinz got desperate, broke into the man's store, and stole the drug for his wife. Should the husband have done that? Why?

Kohlberg used the answers to the preceding questions as a means of evaluating the moral development of individuals (11). Those who

claimed Heinz should be jailed for stealing the drug were classified as first-level reasoners because they were motivated by concerns about punishments. Those who felt he should have stolen the drug were classified as level-two reasoners because they based their decision on the benefit to be obtained by saving the life of Heinz's wife. Both of these levels were mainly evident in pre-adolescent children.

Adolescents tended to exhibit the conformity to others' expectations or laws, which is characteristic of third- and fourth-level reasoning. A 17-year-old, for example, said that the druggist did not "have the right to change so much" because "laws are set up to organize people" in a manner that allows everyone to buy what they need. He also offered reasons based on a sense of responsibilities arising from special relationships. "Because they are married," he said, Heinz must steal the drug to save his wife's life (11, p. 127). As we will see in what follows, responsibilities based on affective relationships may be afforded a higher status than Kohlberg allowed. For him, none of the four levels illustrated mature moral reasoning.

When Kohlberg's model was applied to female subjects, they generally did not match the level of moral development reached by their male counterparts (10). Females tended to concentrate more at the conventional level of morality, where fulfillment of others' expectations was more compelling than abstract considerations of justice. The gender imbalance apparently prodded Carol Gilligan, Kohlberg's student, to conduct a similar study with two differences: Gilligan used an actual rather than hypothetical dilemma for her respondents, and surveyed girls and young women rather than boys or young men. She questioned Kohlberg's claim that a model of moral reasoning derived exclusively from research on males was applicable to women or to humankind in general. She also questioned whether answers to questions based on hypothetical dilemmas were as reliable a rendition of one's actual moral values or principles as would arise from real situations.

Gilligan went about her remedial project by choosing an actual dilemma that girls and women face in their own lives: what to do about unwanted pregnancies (3). The reasons her subjects gave for their choices were different from a rather prevalent but simplistic

construal of decisions in that context. Oftentimes, the decision to continue an unwanted pregnancy is viewed as altruistic or other-centered, whereas the decision to end a pregnancy is seen as self-centered or selfish. In other words, abortion decisions generally assert self-interest or individual rights, while decisions to continue a pregnancy manifest a sense of relatedness and obligations to others. In Gilligan's research, most women who decided to terminate their pregnancies based their decisions not on self-interest but on concern for others. They typically were motivated by a desire to preserve their relationships to others affected by the pregnancy—for example, their already-born children, or their husbands or partners. Their desire to care for others and to fulfill their responsibilities to those to whom they were already related by familial or affective ties superseded their obligations to the fetus. They thus saw themselves as having unequal obligations to different individuals. This parallels the way in which health-care givers define their obligations to patients as more compelling than those towards non-patients. It may also justify health-care givers giving priority to their obligations to family members over obligations to patients from time to time.

Gilligan's early work outlined different levels of moral development. In the first (preconventional) level, the central issue is survival; decisions are motivated by a desire to fulfill one's own needs in a context where one feels very alone. After asserting a sense of self as legitimate, the individual develops a capacity for social participation and responsibility for others. The second level is one where the central issue is that of avoiding harm to others. The ideal is altruism or self-sacrifice.

Next, the agent begins to recognize that morality involves responsibility for oneself as well as others. She gradually reasserts her own interests or needs, while continuing to act in behalf of those to whom she is related. At the third level, a reconciliation is accomplished between selfishness and self-sacrifice. The person is morally mature to the extent that she recognizes that both represent moral obligations or values.

Other current writers have elaborated an ethic of care on a philosophical level. Two of these, Nel Noddings (17) and Sara Ruddick (19), point to maternal nurturance as the paradigm for caring. Noddings distinguishes between the natural caring of maternal nurtur-

ance, which occurs with little or no deliberation, and ethical caring, which involves deliberation. Ethical caring is present within the clinician-patient relationship, and in any relationship in which individuals exhibit "engrossment" and "motivational displacement." For Noddings, "engrossment" is an ongoing concern for another person; it corresponds to the dictionary's definition of care as a troubled or burdened state of mind, the burden being the interests of the other. "Motivational displacement" refers to an identification between the other's interests and one's own. This concept is analogous to empathy because it entails a sense of the other's needs or feelings. It is broader than empathy, however, because it means that the other's needs or feelings really are mine as well. In health care, motivational displacement means not simply that I am disappointed when a patient suffers pain or loss of mobility, but I suffer the pain and loss myself. In advocating for patients, I am thus advocating for myself.

Ruddick describes maternal nurturance as a mode of thinking and practice that may be undertaken by men as well as women, and argues that peacemaking is a logical extension of this nurturance. Since peacemaking entails the healing of divisions, there is an obvious parallel between this and the healing that health care, including pharmaceutical care, involves. But peacemaking, viewed on a world scale, obviously involves more than health care or pharmaceutical care.

Care is sometimes defined so broadly that it is not only compatible with peacemaking, but demands efforts to heal the world. Berenice Fisher and Joan Tronto, for example, define care as "a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible." Such caring, they claim, "includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web" (1, p. 40). Care as nurturance thus has a virtually unlimited agenda.

Care-based ethics is more concerned with context than abstraction. Noddings and Ruddick explicitly eschew considerations of equality because they believe them to be abstract, ignoring the particularity of relationships and attachments to others. The pharmacist who serves his customers at the neighborhood drug store,

knows not only their ills and pharmaceutical needs but also knows them as individual persons. This kind of care is not necessarily egalitarian. Care-based reasoning focuses on preservation of attachments rather than on impartiality or universalizability. Gilligan's view of the different emphases of an ethic of care and an ethic of justice (3) may be formulated as follows:

Care	Justice
Attachment	Detachment
Relationships	Individual Rights
Partiality	Impartiality
Particularity	Universalizability
Context	Abstraction

Through its emphases on context and particularity, a care ethic is case-based, as is health care in general, including pharmaceutical care. Feminists have been concerned that this emphasis on care and relationships may reinforce the stereotypic conception of women as principal caregivers, both formally and informally, throughout history and throughout their lives. Admittedly, the stereotype is based on the fact that women predominate in caregiving roles. Its reinforcement is troublesome because caregiving has generally been less rewarded and less respected than non-caregiving social roles. The non-caregiving roles are often occupied by individuals who achieve their success in a competitive atmosphere where rights, justice, and impartiality are the principal moral concerns. Women may be exploited precisely because of their care orientation.

In addition to feminist challenges to a care-based ethic, some researchers have challenged the validity of Gilligan's work and its conclusions. Lawrence Walker, for example, did a meta-analysis of 79 studies of sex differences in moral reasoning. He concluded that sex differences are nonsignificant and that the moral reasoning of males and females is more alike than different (21). Just as Gilligan has disagreed with Kohlberg, critics may dispute her or her colleagues' interpretation of reasons people give for their decisions as care-based or justice-based. Some statements seem interpretable in either or both ways. It may also be argued that the meanings of care

and justice are not clearly enough distinguished or defined by the interviewers, interviewees, or their interpreters.

Gilligan herself, particularly in her later work, has not made universal or normative claims regarding gender differences in moral reasoning (3). Putting aside the unaddressed question of whether gender differences are naturally or socially induced, her overall project is descriptive. Gilligan's conclusions hardly reflect an effort to stereotype women as care-based reasoners or men as justice-based reasoners. Nor do they reflect any judgment regarding the superiority of care or justice as a moral norm. Gilligan merely presents data indicating that more women than men are care-based reasoners and vice versa. Her own numbers show that it would be wrong to universalize on this basis (5).

Citing a study of adolescents and adults describing a moral conflict that they had faced, Gilligan claims that both men and women rely on justice as well as care considerations in their moral reasoning (4). Among the women in the study, about one-third focused on care, one-third focused on justice, and the remaining third equally used both types of considerations. All but one of the men in this study were more likely to focus on justice than care if they focused on either, but one-third of the men had neither focus. Gilligan does not stretch the data farther than it goes. Instead she suggests that moral reasoning by either men or women straddles both kinds of considerations, like two sides of the same vase. Another analogy she uses is that of ambiguous figure perception. "People," she says, "can see a situation in more than one way, and even alternative ways of seeing, combining them without reducing them—like designating the rabbit-duck figure both duck and rabbit" (4, p. 30).

Gilligan's acknowledgement of the limitations of both perspectives is illuminating and helpful to those who wish to avoid the liabilities of an exclusive focus as well as those who want the nonfocusing perspective to be appreciated in its own right and within the context of their own gender identity:

The potential error in justice reasoning lies in its latent egocentrism, the tendency to confuse one's perspective with an objective standpoint or truth, the temptation to define others in one's own terms by putting oneself in their place. The potential error

in care reasoning lies in the tendency to forget that one has terms, creating a tendency to enter into another's perspective and to see oneself as "selfless" by defining oneself in other's terms.

These two types of error underlie two common equations that signify distortions or deformations of justice and care: the equation of human with male, unjust in its omission of women; and the equation of care with self-sacrifice, uncaring in its failure to represent the activity and the agency of care. (4, p. 31)

Admittedly, this account does not provide an overarching theoretical framework for assessing the moral judgments of individuals or groups of individuals. Gilligan's views have been both supported and challenged in different studies; interpretations of interview responses are challengeable as well. Responses that allegedly signify caring and concern about relationships may also be construed as indicative of concerns about justice or fairness. Moreover, care may be interpreted as entailing justice or justice as entailing care, leading to the futility of attempts to distinguish between reasons as care-based *or* justice-based. Before examining the possibility of combining the two, however, we need to consider the relationships between an ethic of care, health care, and pharmaceutical care.

A Care Ethic, Health Care, and Pharmaceutical Care

In diverse health-care settings, the term "treatment" is often used interchangeably with "care" (15). Clinicians, for example, often speak of "terminating care" for a particular patient for whom continued treatment appears futile or inhumane. An understanding of care as nurturance is at odds with this usage because care as nurturance should never be terminated or limited. Medical treatment, in contrast, should at times be terminated or limited in order to fulfill the goals of care as nurturance. Similarly, pharmaceutical care is not equivalent to pharmaceutical treatment. A caring clinician is not one who provides maximal treatment regardless of the circumstances; a caring pharmacist is not one who supplies the full

arsenal of available drugs for treatment of specific patients. A caring clinician or pharmacist provides treatment that is optimal rather than maximal for each patient.

Just as health care is a broader and more demanding concept than health treatment, care is a broader and more demanding concept than health care. A care ethic is not only concerned about health but also about values and principles that do not relate to health. These may include concepts such as dignity and autonomy. A caring clinician is one who cares for more than the patient's health; he or she cares as well for social and spiritual needs and desires. At times this kind of caring requires the subordination of considerations of health to considerations of respect for a patient's preferences. It sometimes happens, for example, that a patient declines recommended treatment, including pharmaceutical treatment, for religious or moral reasons. Caring in such cases means something different than health care.

The application of a care ethic to pharmacy requires consideration of the relationship between the pharmacist and the client or patient. Note that the term "client" suggests an active role while the term "patient" suggests a passive role. The term "patient," which so dominates discussions of professional responsibility in health care, fits well within the traditional paternalistic construal of the relationship of caregiver to the one cared-for.

Put simply, a paternalistic model reflects the Hippocratic doctrine that the clinician alone should decide what to do to promote the health or preserve the life of a patient (15). Applied to pharmacy this means that the pharmacist determines what is best for the patient and attempts to have the patient follow his or her recommendation regardless of whether the patient is willing to do so. In the jargon of bioethicists, beneficence towards the patient trumps the patient's own autonomy. Of course, to the extent that the patient is not autonomous, or the pharmacist is not free to determine what treatment the patient receives, the pharmacist is not paternalistic. A practitioner is paternalistic if he or she overrides the patient's wishes to promote a therapy for the patient. If a physician or an institution compels the pharmacist to provide drugs that the patient has refused, it is the physician or institution that is paternalistic. The

physician or institution is then acting paternalistically towards the pharmacist.

In contrast to paternalism on the part of the practitioner, consider a model called "instrumentalism" (14). This model views the relationship as one in which the client or patient determines what shall be done or not done. The caregiver thus acts solely as the instrument of the client's wishes; the client's autonomy trumps the clinician's obligation of beneficence towards him or her. An instrumentalist model is also applicable to the traditional notion of the pharmacist as the handmaid of the physician, in which case, the physician's autonomy trumps the autonomy of the pharmacist and beneficence towards the patient.

A phrase often used by clinicians to define their role is that of "patient advocate." Unfortunately, these words are ambiguous in their implications. To advocate for someone may mean to support their welfare *or* their wishes; it may thus exemplify either paternalism or instrumentalism. If the patient is not autonomous, however, patient advocacy is based on beneficence towards the patient; this is not equivalent to paternalism because it does not involve the violation of autonomy.

Another view of the pharmacist's role is the covenant model. Charles Hepler and Linda Strand define this as "a mutually beneficial exchange in which a patient promises to grant authority to the provider, and the provider promises competence and commitment (responsibility) to the patient" (8, p. 12S). The term covenant has a solemn and religious connotation, based on the primordial covenant between God and humankind (9). In that covenant, however, the relationship is hardly beneficial to both parties. God's condition cannot be improved through the beneficence of others, as the pharmacist's condition may be improved through the income generated by the provision of drugs to others. Moreover, God's authority is already established, regardless of whether it is granted by others.

A crasser formulation of the pharmacist-other relationship is that of the provider-consumer. Here also there is "a mutually beneficial exchange" between the pharmacist who is paid for his or her expertise or provision of drugs and the customer who is expected to benefit from taking the drugs. While caregivers tend to resist this language, the formulation entails a recognition of benefit and auton-

omy on both sides of the relationship. It thus represents the obligations of both of the parties involved to respect autonomy and to practice beneficence.

Another possible formulation of the pharmacist's caregiving role involves the analogy between health-care giver and parent. Let us call this model "parentalism" (15). Parents, after all, are our principal caregivers as children because they have a certain knowledge and experience that we lack and because they typically love or care for us more than anyone else. The term "paternalism" derives from the role of the father (*pater*) as protector of the child from the risks of his or her own choices. Based on that meaning, mothers may be paternalistic as well. However, if we think of the mother's role as epitomized in the first great event through which a woman becomes a mother by pushing the child out of her body into the world, to be separate from her, then we have a different emphasis: a thrust towards independence. Clinicians have a similar nurturant responsibility: to help clients or patients to reach a point where they will no longer be dependent on them, their presence, their procedures, or their drugs. While any of these resources may facilitate the well-being of clients or patients, the goal is that they be as independent as possible.

The parentalist model permits recognition of a significant challenge that parents eventually face: to treat adult children as adults. Pharmacists deal mainly with adult children, whose wishes and welfare cannot and should not be controlled totally on grounds of the pharmacist's own expertise. Rather, pharmacists have experience and knowledge that is useful to others, just as parents have with regard to their adult children. Because the pharmacist cares about clients or customers or patients, he or she is happy to share whatever knowledge or experience may be useful. Adult children are obligated not only to respect the knowledge and experience of their parents, but to identify ways of indicating their gratitude. Utilization of pharmaceutical services and payment for drugs are means through which the parental role of pharmacists is acknowledged.

The analogy between parenting and health care has its limits, as does any analogy. But whether or not health care is modeled on

parentalism, recent criticisms of an ethic of care need to be addressed.

Criticisms of an Ethic of Care

Criticisms of an ethic of care fall into two categories: pragmatic and foundational (16). The first foundational (or theoretical) criticism is that the meaning of care is so vague that it provides too little guidance for personal or policy decisions. One of the recurrent criticisms of ethics and ethicists is that they provide no clear answers, no textbook diagnoses, and no treatment plans. Many physicians would like a recipe book for ethics comparable to the dosage book they have for prescribing drugs. As more enlightened physicians and pharmacists know, however, the recipes are never adequate because individuals are always different. Each requires expert interpretation that precludes cookbook answers.

The second foundational criticism is that a care ethic is not sufficiently grounded because it does not tell us *why* we should care for anyone or everyone. Rita Manning offers some responses to this criticism, but basically thinks it doesn't deserve an answer. Nonetheless, she points to the tradition that answers the question by describing people as inherently valuable, endowed with inviolable rights that others are bound to respect. She also offers the utilitarian rationale that caring for people increases the overall happiness of humankind (16).

Why should a pharmacist care for his or her clients or patients or customers? We may answer the question as Manning did—by denying its relevance, by claiming that people in general deserve to be cared for, or by arguing that caring has better consequences for all of us than not caring. These responses may not be adequate either separately or cumulatively to account for the ethical imperative to care. Yet they need not provide a decisive argument if caring is a choice of individual caregivers. Just as some but not all people choose to care for strangers, the same may be true of pharmacists with regard to their patients.

Pragmatic (or practical) criticisms of an ethic of care are more numerous. One is its psychological nonfeasibility. As Joan Tronto puts it, "caring will always create moral dilemmas because the needs for care are infinite" (20, p. 137). It is impossible for any one

individual, or even for groups of individuals, to render perfect or complete care to another. Not only are caregivers limited in their energy for fulfilling the affective dimensions of caring, they are also limited in their ability to perform all of the tasks that caring entails. The pharmacist, for example, has only so much affective energy to apply to clients, who vary in demands and compatibility as well as needs. The pharmacist also has a limited area of expertise. Other people's expertise is required to meet other needs of caring.

The second pragmatic criticism of a care ethic goes beyond feasibility to ethics. Even if a clinician were equipped and able to optimally care for a particular but demanding client, would this be fair to the clinician? What about the possibilities for exploitation that a care ethic involves? This criticism is particularly concerned with the burden that a care ethic places on women, who are socialized to be the principal caregivers of others, both formally and informally. Identifying a care ethic with feminine reasoning may exacerbate this burden. If pharmacists define their caring function in a very limited way, this problem probably does not arise. But a care ethic does not support so limited an interpretation of the term.

A third pragmatic criticism is the incompatibility between an ethic of care and the health, care system. The key word for understanding this criticism is "system." Although clinicians may take pride in the personal nature of their commitment to patients, the system itself is largely impersonal, curtailing the extent to which a personal commitment to patients or clients can be fulfilled. As health-care reform gets more bureaucratic, health "care" becomes more impersonal. If we believe that provision of drugs is equivalent to care, a personal commitment is hardly necessary. But an ethic of care demands that commitment. As Manning describes it, care is necessarily "parochial" rather than impersonal (16).

Finally, a care ethic raises issues of paternalism. The caregiver may be paternalistic in two ways: by acting coercively or manipulatively to promote a health benefit for the client, and by ignoring the responsibility of the client for his or her own health or welfare. In both cases, the autonomy of the client is subordinated to what the clinician perceives as the client's best interests. If a care ethic is interpreted within the context of parentalism rather than paternalism, the clinician will maximally respect the autonomy of the client,

offering rather than imposing information, attempting to persuade but not coerce the client to follow appropriate pharmaceutical recommendations.

Possibilities for Joining Care and Justice

As already indicated, care and justice have been identified as distinct ethical frameworks, one more feminine and the other more masculine, one supposedly new and the other traditional. Care emphasizes relationships, responsibility, and attachments to others; justice emphasizes individual rights, equality, and impartiality. If a gender difference is evident in the moral reasoning of practitioners it is most likely to show itself in the less rewarded and less prestigious professions and in the lower ranks of the more rewarded or prestigious professions because that's where women predominate.

Why is the number of women in caregiving roles greater than that of men? It may be that a care ethic is more evident among women than men not because of their gender difference but because of the differences between them and men in prestige and income related to their societal or professional positions. Sandra Harding has compared African and feminine moralities and found a common denominator in their tendency to affirm the difference of their respective groups by distinguishing themselves from the dominating class of white European men (6). Both Africans and women, she says, are less concerned with autonomy and rights than with relations to others and to nature. Africans of both sexes are more likely than white European men to exhibit care-based reasoning.

In light of the strengths and weaknesses of both care and justice frameworks for moral reasoning, a number of authors have proposed that justice and care be joined in the same ethic. Marilyn Friedman (2) and Virginia Held (7), for example, have argued that care and justice are compatible. It may further be argued that they necessitate each other. The supposedly caring parent who permits a child to totally ignore or oppose the parent's welfare or wishes is acting neither justly nor caringly towards the child. Allowing oneself to be manipulated or exploited by another does not constitute caring for him or her. Similarly, if every person deserves a certain amount of care, especially from those closest to him or her, this is

also a matter of justice. Care and justice may thus be different but complementary models of moral reasoning.

The necessity of combining justice and care models of reasoning seems particularly pertinent to pharmaceutical care. Take the example of the pharmacist in the case described by Kohlberg. Heinz's wife was the client who needed the drug that the pharmacist had to sell. A care ethic unmediated by a justice ethic might claim that the pharmacist should give the drug to Heinz without charge. After all, the pharmacist would undoubtedly give the drug to his wife or daughter if she needed it, and a care ethic is modelled on that type of relationship. But Heinz is not so poor that he can pay nothing for the drug, and if the pharmacist simply gave his drugs away to everyone on grounds that he ought to treat them like his own wife or daughter, he would soon be out of work, and that doesn't seem fair or just. What does seem both just and caring is that Heinz pay what he can for the drug, without reducing himself and his wife to penury, approaching as reasonably as possible the amount that the pharmacist might expect others to pay for the drug in a free and open market.

Admittedly, this example does not fit a system in which the pharmacist cannot or does not set his or her own prices for drugs. It does apply, however, to those who set the prices, and others who have obligations to those who cannot pay for treatments essential to themselves or their loved ones. In our society, those who ultimately pay for necessary treatments for those who cannot pay for themselves are taxpayers. Despite the unpopularity of taxes, in a society of just caregivers they provide tangible recognition that all of us are responsible for one another.

To return to the analogy between parenting and health care, a parentalism ethic demands both maternal and paternal elements on the part of the practitioner. Just as each child deserves two parents, and adequate parenting (whether this involves one or two parent figures) entails protection from harm as well as nurturance towards independence, so justice and care are both required in an adequate ethic. Pharmaceutical care needs to emulate a parental role by recognizing the differing and changing requirements for care and justice on both sides of the relationship.

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