

2019

# Caregiving and the Abuse of Power

Joseph Walsh  
*Independent Researcher*  
j.p.walsh@hotmail.co.uk

---

## Recommended Citation

Walsh, Joseph. 2019. "Caregiving and the Abuse of Power." *Feminist Philosophy Quarterly* 5 (3). Article 3.

## Caregiving and the Abuse of Power

Joseph Walsh

### Abstract

Caregiving relationships are often characterized by an imbalance of power between the caregiver and her cared-for. The danger that this power will be abused is a source of serious moral concern. In this article, I argue that the risk of an abuse of power sometimes stems not from the possession of power itself but from the very nature of caring relationships. This is because carers must be prepared to exercise nonminimal amounts of power over their cared-fors, even if doing so is likely to cause the cared-for distress or even pain. This means that caring itself, rather than the malign influence of power dynamics, generates a risk of unintentional abuse. I argue that this risk can be reduced by trying to avoid an exclusive focus on the outcomes of care and by paying more attention to the way in which that care is delivered.

**Keywords:** care ethics, morality, power

### 1. Introduction

Relationships of care often give rise to ethically charged power dynamics. On the one hand, cared-fors are in a position to exercise power over their caregivers. They may, for instance, have psychological power over them, such as the power to cause emotional distress by denigrating their attempts to provide care or by blaming them for not doing more, thereby prompting feelings of guilt. Cared-fors can also have financial or social power over their caregivers. For example, if a caregiver is employed to provide care, then they risk unemployment and financial difficulty if they fail to act as their cared-for believes they ought. Alternatively, when a higher social status is conferred on a cared-for by virtue of their race, gender, or socioeconomic class, they may feel able to use this status to pressure caregivers into providing excessive amounts of care. Power inequalities such as these, then, expose carers to the risk of exploitation and even abuse from their cared-fors.<sup>1</sup>

---

<sup>1</sup> As noted by Kittay (1999, 35).

On the other hand, those who require care often do so because they lack the power to meet certain needs through their own agency. Such dependency can therefore provide caregivers with a considerable degree of power over their cared-for. Carers may, for example, have epistemic power over a cared-for, such as the authority to claim which forms of care (e.g., medical treatment, physical therapy) are required. They may have legal power, such as the right to make life-changing decisions on the cared-for's behalf, to have them hospitalized or institutionalized, or to sell their property to finance further care. Carers may also have psychological power over a cared-for, such as the power to persuade, manipulate, or emotionally influence the cared-for's judgments. Finally, they may have physical power, such as the power to administer medication (if necessary, by force), to restrain, or to prevent the cared-for from exercising their agency in ways which the caregiver deems inappropriate.

These unequal distributions of power are often seen as the source of potential moral wrongdoing (e.g., Barnes 2012, 23; Bubeck 2002, 171–172; Phillips 2007, 144), and it is easy to see why: power confers upon its possessor the ability to subordinate the interests of others to their own, and to act on self-interested desires without fear of adverse personal consequences. In what follows, I will focus specifically on the power possessed by caregivers and on how and why that power may sometimes come to be misused.

We might be tempted to think that power has an intrinsically morally corrosive effect and that its misuse is simply a result of this corrosion. To dig no deeper than this, however, is to fail to ask interesting, and philosophically important, questions. Why is it that carers who genuinely want the best for their cared-for sometimes end up misusing the power with which they are entrusted? How is it that genuinely caring intentions can sometimes lead to the commission of acts which do violence to the very person whose interests are supposedly being looked after?

In this essay, I provide a partial answer to these questions. My answer is only partial because power comes in many different forms, and its use has many different manifestations. Here, I am interested in quite a narrow range of these. Specifically, I am interested in power as it is used to influence the behaviour of others. It should be noted that I am using the phrase “to influence behaviour” in a broad sense. According to this usage, an agent's behaviour has been influenced if she is caused to do something which she would not have done had she not been so influenced. This influence might be psychological, such as threats or some other form of coercion, and of course it might be physical, such as being picked up and

carried from one location to another.<sup>2</sup> Even within the confines of this narrow focus, however, a closer look at the power dynamics found in caring relationships has the potential to shed interesting new light on the subject. Specifically, it will be seen that it is not the nature of *power* which generates the risk of its misuse but instead the nature of caregiving.

In section 2, I show that, far from being an undesirable feature of good caring relationships, the exercise of power over a cared-for is often an enabling condition of good care. Without it, caring relations are sometimes impossible to sustain, and the provision of certain important goods is sometimes impossible. In section 3, I argue that there is a grey area concerning how much of their power a caregiver may permissibly exercise over a cared-for. Carers must often be prepared to use some nonminimal degree of power in their provision of care, even if doing so will predictably cause their cared-for to experience distress or even pain. This makes it very difficult for carers to recognise (or for philosophers to specify) the precise point at which the legitimate *exercise* of power becomes an illegitimate *misuse* of power. Then, in section 4, I propose a values-based approach to the evaluation of a caregiver's use of power. I identify a number of values associated with caring, and argue that the misuse of power can occur when carers become exclusively focussed on just one of these, thereby neglecting the others. By placing a greater emphasis on the plurality of values involved in good care, it becomes possible to aim at a "balanced" approach to caring, which is properly responsive to each of these values. Such an approach, I argue, is less likely to lead caregivers to misuse the power which they have over their charges. Finally, in section 5, I reply to some possible objections to my account.

## **2. Power as Constitutive of Good Care**

Caring relationships are often relationships in which there is an unequal balance of power between the cared-for and her caregiver.<sup>3</sup> Indeed, it is sometimes precisely the cared-for's lack of power which generates the need for care. Thus, as Joan Tronto writes, "if people didn't have needs that they needed others to help them meet, there would be no care" (1993, 170). Similarly, Eva Feder Kittay writes that "the inequality of power is endemic to dependency relations" (Kittay 1999, 34). Infants and young children, for example, depend entirely upon the power of a caregiver to meet even their most basic needs.

---

<sup>2</sup> The example of being carried should alert the reader to the difference between "being caused to do something" and "acting", and to my focus on the former.

<sup>3</sup> This is often the case, but it need not always be the case. One can imagine, for example, caring relationships between siblings or spouses which are not characterised by significant power inequalities.

For both Tronto (1993, 170) and Kittay (1999, 35), as well as for other writers on care (e.g., Barnes 2012, 23; Ruddick 1995, 213; Phillips 2007, 143), this imbalance of power generates a risk that the caregiver's power will be misused, and that as a result of that misuse, caring will deteriorate into paternalistic abuse. Of course, as Kittay has also observed, the mere presence of an imbalance of power does not suffice to make caregiving abusive: "not every [power] inequality amounts to domination" (Kittay 1999, 34). Still, legitimate concerns about the potential for abuse might lead one to think that, whilst power discrepancies in caregiving relationships may sometimes prove to be unavoidable, carers would be well advised never to *exercise* their power over a cared-for. According to this thought, by refusing to exercise however much power they may have, carers can effectively eliminate the risk that they will misuse their power in an abusive way.

Some further consideration, however, shows that this is by no means good advice for caregivers to follow. Not only is the use of power in caregiving sometimes permissible, it is also sometimes required. Virginia Held, for example, notes that the use of physical force to "yank a child out of the path of an oncoming car" may be called for, even if that force is so great that the child is injured as a result of its use (Held 2010, 121). The same thought has also been expressed by Sarah Clark Miller, who writes that firefighters may, during the course of a rescue, "engage in behaviour that we would not normally understand to be a pattern of good care," such as intentionally breaking someone's leg in order to free them from being trapped in the path of the encroaching fire (Miller 2012, 87). Of course, for these remarks to be true, it must be assumed that such force is proportional to the urgency of the situation; that is, that no lesser (and thereby noninjurious) degree of force would have been sufficient to save the lives of those endangered. With this assumption in place, however, claims such as these are surely correct.<sup>4</sup>

Of course, examples like those considered above are extreme and serve only to establish that, in dire situations, caregivers might properly be called upon to exert their power over a cared-for. Yet the legitimate use of power in the provision of care actually extends far beyond life or death scenarios such as these. Indeed, the use of power permeates even some of the most commonplace caregiving activities. Consider, for example, a variety of situations that the carers of very young children might encounter on a daily basis. As the reader may be aware, children are not always perfectly compliant with their carers' wishes. Indeed, they may sometimes actively resist a carer's efforts to provide that which she takes (we may stipulate correctly) to be necessary for the child's well-being. The reader may also be aware

---

<sup>4</sup> Although the examples in this paragraph both relate to the use of physical force, it should be kept in mind that power may also be exercised through nonphysical means. For an example of this, see the discussion of Florence in section 3.

that children are not always perfectly responsive to reasons. That is, whilst a child might be able to *understand* the reason why it is in her interest to comply with her carer's wishes, she may not always be able to use that reason to form an appropriate set of action-guiding desires. Thus a two-year-old might, for example, refuse to allow her teeth to be cleaned; refuse to get dressed; refuse to take unpleasant tasting medicine; refuse to allow a splinter to be removed from her foot; refuse to sit in her booster seat during car rides; or refuse to comply with any number of other day-to-day, care-oriented activities.

How will a caregiver respond to such refusal? There are, of course, a number of approaches which she might try. She might, for example, defer the resisted course of action for a period of time, perhaps waiting until after the child has slept or eaten, in the hope that things will go more smoothly later. She might try to reason with the child or to persuade or cajole her in some other way. Alternatively, she might try to turn the objectionable activity into a game of some sort, thereby encouraging the child to view the activity as something fun rather than as something to be resisted.

Approaches such as these are likely to be effective at least some of the time. They will not, however, be effective *all* of the time. When they are not, the carer will have no choice but to enforce compliance: sometimes children just have to be strapped into their booster seats whether they like it or not; sometimes they just have to take their medicine; sometimes they just have to clean their teeth. On such occasions, then, the carer will exercise her power over the child in order to bring about the desired state of affairs. This power might be physical (e.g., holding the child in place), or it might be psychological ("if you don't take your medicine, we won't go to Henry's birthday party"). Of course, saying this is by no means to sanction the use of extreme or unnecessary force. Nevertheless, when a child is being held in place, against her will, so that she can be strapped into a car booster seat, she is unequivocally on the receiving end of her caregiver's power.

There are, then, many possible examples of carers using their power over a cared-for to further the ends of caregiving, in situations which are entirely commonplace and non-life-threatening. Furthermore, it is clearly morally unobjectionable for carers to use their power in this way. Indeed, for them not to do so (e.g., by allowing a child to ride in a car without being securely restrained) would be to endanger their cared-for's life. Without exercising power in these ways, then, caregivers would be failing to act as they ought.

This claim is not restricted to the case of parenting. Other forms of care also require the judicious use of power at certain times. In her study of student teachers' conceptions of caring, for example, Carol Weinstein (1998) stresses that the best forms of educational care are those which combine elements of personal and

emotional connection with a more disciplinarian focus on controlling students' behaviour and ensuring their obedience to classroom rules.

Weinstein describes how student teachers who conceive of caring exclusively "in terms of nurturance, warmth and empathy" (1998, 155) find it extremely difficult to create learning environments in which students are able to thrive. For these teachers, that is, caring stands in opposition to authoritarian attempts to impose order and discipline on the classroom (Weinstein 1998, 160). In trying to create maximally caring environments for their students, then, these student teachers neglect the enforcement of rules and reject "managerial" forms of interaction with their students, such as establishing clear behavioural expectations and consistently dealing with behaviours deemed inappropriate. However, if these authoritarian aspects of teaching are neglected for too long, Weinstein observes, it can lead to the creation of environments "so chaotic and so confused that no learning, teaching, or caring [is] possible" (1998, 153).

What Weinstein is criticizing here is a conception of caring which excludes the judicious use of power. Student teachers who subscribe to this conception see caring for students and maintaining discipline in the classroom as two *separate* activities. From this perspective, the more time one spends enforcing rules and policing behaviour, the less time there is available to spend in caring for one's students. Weinstein rejects this conception of care in favour of an alternative approach according to which the use of power to maintain discipline is partially *constitutive* of caregiving. In support of her view, Weinstein writes that "caring can also include a commitment to creating an orderly environment in which children can flourish" (1998, 154). Weinstein notes that this conception of caring is one which has, at times, been explicitly endorsed by some student teachers (Weinstein 1998, 154).<sup>5</sup> There also seems to be some acceptance of this conception amongst students themselves, who describe a caring teacher as, in part, one who makes an effort to create a safe, controlled learning environment (Weinstein 1998, 162). Weinstein summarizes these thoughts by referring to a remark made by George Noblit (1993, 24), which she quotes approvingly (Weinstein 1998, 154): "Caring in classrooms is not about democracy—it is about the ethical use of power." Thus, just as in the context of caring for children, providing educational care may also require a willingness to exert one's power over a cared-for. This is a position which not only has been accepted by those working in education and education research but which also seems to find at least tacit acceptance among students themselves.

Of course, some sceptics may still wish to draw a clear distinction between exercising power on the one hand and caring on the other. Before doing so,

---

<sup>5</sup> Obviously, not the same student teachers who take care and discipline to be diametrically opposed to one another.

however, they should recall the emphasis which those working on the ethics of care typically place on the active nature of caring. For many writers on care ethics, caring is not simply a feeling of benevolent concern; rather, it is also a form of activity. As such, caring not only *aims at*, but also *brings about*, some improvement in the condition of the cared-for (see, for example, Bubeck 1995; Held 2006; Kittay 1999; Noddings 1984; Tronto 1993). This claim draws support from the way in which the concept of caring is used outside of philosophical contexts. Imagine, for example, a carer who through inattention or lack of skill actually harms her cared-for. We would not say of this carer that she is actually providing care. Rather, we would say that on this occasion she has *failed* to care, even though her intention to care may have been genuine. Thus, to say that an agent is caring is to say that her attempts to provide care are meeting with at least some minimal degree of success; it is to say that her actions are *good enough* to be described as caring.<sup>6</sup> Now, as Weinstein's discussion makes clear, when student teachers excise the use of power from their caregiving activities, they create environments in which the aims of educational care simply cannot be met (Weinstein 1998, 154). A rejection of the use of power, in other words, leads to a failure to provide care. The practical aspect of caregiving, then, makes it very difficult simply to reject the claim that the use of power is sometimes an element of good care.

In this section I have argued that it is sometimes necessary to exercise power in order to provide adequate care. This is something which has been previously recognised in the literature on care ethics, but that recognition is typically made in a way which suggests that the use of power will be the exception rather than the rule, something which occurs only in situations of dire need. On the contrary, however, even the most everyday instances of caregiving will often call for the caregiver to exercise power over her cared-for. The use of power in this way is, in and of itself, morally unproblematic. However, the need to use power in the provision of care generates a risk that caregivers will exercise *too much* power in pursuit of their caring activities, thereby undermining their care even to the point at which it begins to resemble abuse. One way to avoid this risk would be to specify exactly *how much* power it is permissible for carers to exercise. As will be seen in the next section, however, any attempt to make such a specification will encounter serious problems.

### **3. Identifying the Ethical Limits of Power: Three Difficulties**

So far, we have seen that the use of power is sometimes a necessary and legitimate aspect of certain caregiving practices. Of course, this is by no means to

---

<sup>6</sup> I say that care provision must be at least *minimally* satisfactory to allow conceptual space for the existence of better and worse forms of care. This would not be possible if attempts to care needed to be optimific in order to count as successful.



say that the use of power will *always* be permissible, just so long as it is exercised in the service of some genuinely care-based end. It would not be permissible for an agent to exercise her power over a cared-for, for example, if the end which she is pursuing was attainable *without* the use of that power.

Of course, whilst it is one thing to say that caring agents may sometimes legitimately exercise their power over a cared-for, this is as yet to say nothing about how *much* power it is legitimate for them to exercise. It is surely plausible to think that good carers will aim to use as little power as possible in the furtherance of their caregiving aims. There is a difficulty here, however. Suppose that a carer initially exercises some minimal amount of power, which we will refer to as  $P$ , as a part of her care provision. As it turns out, however, this proves to be an insufficient amount of power for the attainment of her end. She therefore tries again, this time exercising just a little bit more power:  $P^1$ . This is a process which can be repeated an open-ended number of times, until the care-based end at which she aims has finally been attained, through the use of some amount of power,  $P^n$ . Now, the precise value of  $n$  will of course vary from case to case, depending on how much power it was ultimately necessary for the carer to exercise. However, at least some of the possible values of  $n$  will constitute excessive uses of power, and will therefore be morally inappropriate. That is to say, given the amount of power which it was necessary for the carer to exercise to achieve her end, she ought not to have exercised that power and should have given up the relevant end instead. The question is, how are carers supposed, in any given situation, to identify the maximum morally permissible value of  $n$ ? Or, in other words, how are carers to recognize when the amount of power which they are using is excessive in relation to some particular end?

This is a question without a straightforward answer. We cannot simply claim that carers ought always to use only the minimum possible amount of power necessary to achieve their ends, as this is merely a redescription of the morally problematic situation outlined in the previous paragraph. Sometimes, the minimal amount of power needed to bring about a particular end may be so great as to be morally objectionable, and a carer ought to *give up* that end rather than exercise the required amount of power in its pursuit. In other words, some goods are simply not worth attaining if one of the conditions of doing so is the substantial overpowering (whether through physical or mental means) of a cared-for. This will most clearly be the case when the end in question would provide only a marginal benefit to the cared-for. It may also be true even for much greater goods, however, if these are sufficiently difficult for the caregiver to attain. Instructing carers to use the minimum possible amount of force needed to attain their end, then, does not provide a solution to the problem at hand; indeed, it does little more than restate it in an altered form.

An alternative approach is to suggest that the amount of power which carers exercise in the pursuit of their ends ought never to exceed *P*. Unlike the guideline discussed in the previous paragraph, this approach succeeds in restricting the amount of power which it is morally permissible for carers to exercise to a very low level. Unfortunately, however, it is still wholly inappropriate as a normative guideline for practical caregiving. This is because *P* is, by definition, an extremely low value which it will often be appropriate for caregivers to exceed. This will be the case, for example, in the sort of life-threatening situations discussed in the previous section. It will also be the case in situations which are much less extreme, as when unwilling children must be strapped into car booster seats. The problem with this second suggestion, then, is simply that it does not legitimate many uses of power which seem entirely appropriate and wholly morally justified.

A third possibility is that carers ought only to exercise an amount of power which the cared-for experiences as nondistressing. This approach is attractive because it is less vulnerable to the problems discussed above. We might think, for example, that a cared-for would not be distressed by being shoved forcibly out of the way of a speeding car.<sup>7</sup> We might also think that an agent's use of power becomes morally objectionable *precisely at the point at which the use of that power becomes a cause of distress*. Whilst this may be true in many cases, however, it will not be true in every case. As I explain below, sometimes a morally appropriate use of power will foreseeably cause the cared-for distress, even physical pain. For this reason, this third suggestion also fails to identify appropriate limitations on a carer's ethical use of power.

To say that caring can sometimes justifiably cause pain or distress may seem surprising. It is, after all, natural to think of caregiving as a practice which aims at alleviating the distress of a cared-for, by providing comfort, reassurance, and (both practical and emotional) support. Yet whilst this thought is surely correct, it is important also to acknowledge that, if they are to care effectively, carers must sometimes also be willing to cause or to allow a cared-for to become distressed. Of course, this is not the same as saying that a carer will *desire* her cared-for to experience distress. Such a desire would, after all, be incompatible with the attitude of benevolent concern from which we expect carers to act. A preparedness to cause or allow distress, on the other hand, is *not* incompatible with an attitude of benevolent concern if it arises as an inevitable (though undesired) product of morally appropriate care.

The reason for this is that many forms of care may be unwanted by the cared-for and may therefore be experienced by her as unpleasant and distressing. Consider, for example, taking a child to receive a measles immunisation. Having

---

<sup>7</sup> Or at least, that they would find this much *less* distressing than the alternative.

injections can be quite painful, and many children find it highly distressing, even if only in the short term. Despite knowing that her child is likely to be distressed by the injection, a caring parent ought nevertheless to have that child immunised. To refuse to do so would be to expose the child to a serious and unnecessary risk of debilitating illness and death. Such refusal would therefore be constitutive of a failure to provide appropriate care, at least in this particular respect. Similar considerations apply to many other types of parent–child interaction, including trips to the dentist, the administration of unpleasant medicine, or leaving a child at preschool or kindergarten for the first time. Readers who have experience of this will no doubt also have experience (whether in relation to their own child or to someone else’s) of inconsolable children sobbing hysterically because they do not wish to be left by their parents or carers. Nevertheless, these children *are still left*, and their distress is viewed as a highly regrettable, but acceptable (because it is accepted), aspect of promoting greater independence and enhanced social skills.

The observation that carers must sometimes be willing to cause distress is by no means a new one. It has previously been made in the literature on empathy, particularly by writers who are sceptical of attempts to ground morality in empathetic concern, and also in the literature on caring.<sup>8</sup> Whilst this point may not be novel, it is important: caring agents must sometimes be willing to cause or allow their cared-for to experience distress as a part of the provision of good care.

Now, it is plausible to think that there will be a considerable overlap between situations in which caregivers feel compelled to use their power over a cared-for, and situations in which the use of that power is the cause of distress. Some of these have already been mentioned above, for example, when administering medication to a reluctant infant, or when holding a child in place as she is strapped into a car booster seat. In cases of this sort, there is active and ongoing resistance to the caregiver’s actions, and the carer’s implacability in the face of this resistance will often be a cause of distress to the cared-for. Yet this distress does not mean that the caregiver ought to discontinue her efforts.

This willingness to cause distress applies not only to the use of physical power or to the care of young children. To see this, let us consider an example of the use of nonphysical power directed towards an adult. In her study of power relations between aging parents and their children, Karen Pyke (1999) describes the case of Florence and her mother-in-law. Tensions in this relationship are produced by Florence’s repeated attempts to (as she sees it) improve her mother-in-law’s level of care, despite her mother-in-law’s resistance to those attempts.

---

<sup>8</sup> See, for example, Bloom (2016), Collins (2015, 27), Noddings (2002, 63), Prinz (2011), and Slote (2007, 85).

She [Florence] said that even though her 91-year-old mother-in-law, who lives alone, did not want any assistance, Florence “pestered” her husband to hire a woman to provide companionship for her mother-in-law and assistance with bathing and housekeeping. Florence explained, “We decided that this is how it has to be, whether she likes it or not. You can’t always get what you want.” (Pyke 1999, 666)

The case of Florence and her mother-in-law as it is presented here is insufficiently detailed to allow a verdict on whether or not good care was actually taking place. What Florence’s remarks do allow us to see, however, is that Florence (and, according to Florence’s account, her husband) were willing to embark upon a course of action even if doing so would cause her mother-in-law emotional distress: “This is how it has to be, *whether she likes it or not.*” Furthermore, Florence was prepared to take this course of action precisely because she believed that it was the best (or at least an appropriate) way to provide care for her mother-in-law. This shows that a willingness to cause or to allow distress is not confined to the use of physical power or to the context of caring for young children. The idea that a carer’s use of power becomes morally objectionable at the moment it begins to cause their cared-for distress is therefore mistaken. Such an approach cannot, then, provide an appropriate guideline for the ethical limitations of a caregiver’s power.

To recap, in this section we have considered three possible answers to the question of how carers ought to limit the use of their power. Each of these answers failed, albeit for different reasons. The picture of caring which begins to emerge in the light of these failures is one according to which the use of power is an ineliminable aspect of some types of care, and in which there is no obvious way for carers to identify when they are using an excessive, and therefore morally inappropriate, degree of power. It is worth noting at this point that this position does not entail the claim that carers can *never* be in a position to recognise that they are using too much power. Sometimes a carer’s misuse of power may be so great that it will clearly be morally reprehensible both to themselves and to others. There nevertheless exists a morally grey area, of indeterminate size, in which it is possible for carers to use more power than they ought to without any conscious recognition that this is what they are doing. Now, simply recognising this problem as an intrinsic aspect of caregiving relationships is already to go some way towards dealing with it, at least insofar as that recognition can prompt carers to exercise their power more cautiously than they otherwise might. However, as we will see in the next section, it is possible to provide some additional guidance which might help carers to avoid misusing their power.

#### **4. Balanced Caring**

So far, we have seen that the risk of abusing one's power over a cared-for does not stem merely from the *possession* of such power. Rather, it is generated by the combination of a number of features of caregiving itself: that care sometimes calls for a caregiver's power over a cared-for to be exercised; that it is unclear how much power it will be appropriate to exercise in any given instance; and that carers must be prepared knowingly to cause distress to their cared-fors on some occasions.

Each of these claims express genuine features of caregiving. Because of this, it is not fitting simply to advise carers never to exercise their power over a cared-for or never to allow a cared-for to become distressed. To do so would be to undermine aspects of caregiving which are at times both necessary and important. The nature of caregiving itself, then, seems to generate an unavoidable risk of power abuse.

What should care ethicists say about how to minimise this risk? One promising approach is to draw attention to the different types of value associated with caregiving and to encourage what might be termed a "balanced" approach to care, which aims at responding appropriately to each of these values rather than to just one of them. This section outlines just such an approach. In subsection 4.1, I identify some of the values around which caring is, or at least ought to be, oriented. Then, in subsection 4.2, I discuss some of the ways in which caregiving should respond to these values and how this can reduce the risk that abuses of power will occur.

It should be kept in mind that what follows is not intended as a complete account of how carers ought, always and on every occasion, to respond to the values which I discuss. Indeed, I believe that such an account is neither desirable nor, ultimately, possible: moral life is simply too complicated to be fully captured by examples and generalisations. My discussion should therefore be understood not as making a definitive statement about how balanced care will always operate but rather as outlining a framework which can further inform our moral deliberation about caregiving practices.

##### *4.1 Caring Values*

One of the values which guides any form of caregiving is that of the quality of life of the cared-for. The relief of pain, the healing of wounds, and the encouragement of healthy emotional and physical growth are all activities oriented around the promotion of this value. The promotion of a cared-for's quality of life thus constitutes the teleological, or goal-oriented, aspect of caregiving.

This goal is so central to good caregiving that it is tempting to think of it as the primary, or most important, of the values to which caring responds. This thought draws support from the fact, as seen throughout this paper, that a carer's use of power is morally justifiable only when, and because, it is deployed in the service of

this end. Indeed, this is something which caregivers themselves are often aware of, as can be seen when they try to justify their use of power by telling a cared-for that “it’s for your own good.” Despite its intuitive appeal, however, I wish to reject the idea that any one of the values which I consider here is more or less important than any of the others, *tout court*. Assigning priority to a single value in this way would suggest that a carer ought always to promote that particular value above all others. As we will see later, however, this is simply not the case.

Despite its obvious importance, a cared-for’s quality of life is not the only thing which is of value to caring practices. This has convincingly been shown in recent work by Miller (2012, 2017), who argues that dignity is also a vitally important aspect of the caring relationship. Genuinely caring goals can sometimes be pursued in ways which are undignified, demeaning, or dehumanising. When this takes place, Miller argues, it stems from a failure fully to recognise the moral worth of the cared-for (2012, 86). One of the results of this failure is the danger that a cared-for will come to be (wrongly) perceived by others, and perhaps even by herself, as genuinely lacking in moral worth (2012, 83). For this reason, Miller claims, undignified forms of care are in fact “morally impermissible” (2012, 86).

To describe certain forms of care as morally impermissible is equivalent to identifying them as *pseudo* forms of care. Thus, to say that one is caring for someone by treating them in a morally impermissible way is effectively to say that one is not, in fact, caring for that person at all. A claim of this sort is, I believe, precisely what Miller has in mind when she writes that “the duty to care is a duty to deliver *dignifying* care” (2012, 87, emphasis added). For Miller, there is no distinction to be drawn between our duty to care and our duty to do so in a way which dignifies the cared-for.

In addition to quality of life and dignity, caregiving also values the autonomy of a cared-for. The importance of autonomy has been increasingly recognized in recent years, particularly by health care providers (such as the NHS in the United Kingdom) who have emphasised patients’ rights to be included in the decisions about the care which they receive.<sup>9</sup> This right not only includes being involved in decisions about medication and other treatment options, but also extends to the right to refuse certain, potentially highly effective, courses of treatment should a patient wish to do so.<sup>10</sup>

---

<sup>9</sup> See, for example, Coulter and Collins (2011).

<sup>10</sup> For instance, one might for religious reasons refuse blood transfusions or organ transplants. One might also refuse to undergo highly unpleasant treatments, such as chemotherapy, even though there is a chance that they could prove to be highly beneficial.

Of course, autonomy does not begin and end with involving cared-fors in the making of decisions. It also concerns helping them to live the kind of lives which they wish for themselves. A concern for a cared-for's autonomy, then, might call for a caregiver to provide support in the undertaking of various projects which would be impossible without that support. Such projects may be ongoing, such as a weekly trip to the local library; or they may be one-off events, such as attending a birthday party for a relative who lives overseas. More generally speaking, the value which a carer attaches to her cared-for's autonomy ought to lead her to support and enhance that cared-for's agency wherever it is appropriate for her to do so.

The final value which I will identify here as a part of caregiving is the value attached to the maintenance of caring relationships.<sup>11</sup> The importance of this is something which has been stressed many times in the literature on care ethics (e.g., Collins 2015; Kittay 1999; Noddings 1984). Whilst I cannot provide a complete account of the nature of caring relationships here, it is worth briefly drawing attention to two of their noteworthy features. The first of these is that caring relationships are grounded in a commitment to meeting the needs of the cared-for.<sup>12</sup> This does not mean that these relationships will always last a long time. What it *does* mean, however, is that the care which they provide will not be arbitrarily discontinued by the carer. On the contrary, as long as the needs which motivate that care remain, carers will endeavour to meet them. This commitment points to another noteworthy feature of caring relationships. This is that they often involve a degree of trust between the carer and her cared-for.<sup>13</sup> Trust takes time to develop and can be quickly lost if it is betrayed, so good caring relationships ought where possible to be enduring and open, with thoughts and feelings easily shared between carer and cared-for.

#### *4.2 Striking a Balance*

If caregiving is about more than one sort of value—that is, not just about promoting a cared-for's quality of life, but also about respecting her dignity, supporting her autonomy, and maintaining caring relationships—then the best forms of care will be those which manage to respond appropriately to each of those values rather than just to one or two of them. Of course, this is easy to say, but what does it mean in practice?

---

<sup>11</sup> I am open to the thought that a commitment to some further values is implied in caring practices, but I do not have space to conduct a full examination of these here.

<sup>12</sup> This has been claimed by Friedman (1987), Meyers (2004), Noddings (1984), and Tronto (1989), among others.

<sup>13</sup> Cf. Banks 2016; Mullin 2011.

This is a question which does not admit of a single answer. Like many others writing on care ethics, I am deeply sceptical of broad generalisations about what morality requires of us, preferring instead a contextualist, case-by-case approach to moral deliberation.<sup>14</sup> Still, it is possible to say something substantive in response to this question without endorsing a one-size-fits-all approach.

I remarked in subsection 4.1 that none of the values associated with caring ought to take priority, *tout court*, over any of the others. This does not mean, however, that a carer cannot assign relative priorities to those different values *on any given occasion*. What it *does* mean is that how she prioritises them will vary according to the details of the situation in which she finds herself. To see how this might work, consider just two of the values discussed above: quality of life, and autonomy.

In many clinical settings, respect for a cared-for's autonomy will (rightly) take precedence over the promotion of their quality of life. It would be wrong, for example, for a clinician to insist on a particular course of treatment (say a blood transfusion) in the face of a patient's expressed desire not to receive this treatment for religious reasons. On other occasions, however, respecting a cared-for's autonomy may be less important than promoting their quality of life. For example, patients suffering from advanced (or metastatic) cancer may strongly desire an aggressive course of chemotherapy, in the hope that this will send their cancer into remission. Such treatment is not always advisable, however, because it can sometimes result in serious harm to the patient without producing any lengthening of their life expectancy. In such cases, practitioners may refuse to prescribe chemotherapy despite the patient's wishes and choose instead to offer palliative care, aimed at making the patient's remaining time as pain-free as possible. Here, then, we have an example of when it might be appropriate to prioritise the value of a cared-for's quality of life over that of their autonomy.

So, the priority which carers ought to assign to different caring values will vary from case to case. This is not to say, however, that a carer can simply ignore those values which she takes to be less important in the case at hand. Respecting the autonomy of a patient who refuses a life-saving treatment, for example, does not mean that there is no need to make that patient's remaining life as pain-free as possible or to continue to treat her in a dignifying way. Each of the values associated with caring is *always* important, in *every* caregiving context, even when one of them takes priority over the others. Sometimes, in tragic cases, there may be nothing which a caregiver can do in relation to one of those values. In some situations, for example, a carer might be genuinely unable to enhance their cared-for's quality of

---

<sup>14</sup> See, for example, Held (2006, 11), Noddings (1984, 7–8), Sevenhuijsen (1998, 59), and Walker (1989, 19).



life. Even in these cases, however, the value of that quality of life remains, and its inevitable loss should be recognised as a source of deep regret and sorrow.

With all this in mind, I contend that some instances of power abuse in caregiving may be understood as resulting from the neglect of some of the values which I have associated with caring. Consider, for example, the following statement by one of the nurse subjects in a study by Eriksson and Saveman (2012, 81):

We sometimes have to hold [patients] by force to be able to take specimens because we want the patients to get well but you forget to treat them with dignity, as they don't know what is best for themselves.

Here, the value of patients' quality of life is being promoted at the expense of (at least) two other caring values, specifically autonomy and dignity. Now, it may be the case that, in situations such as these, respecting patients' autonomy is simply not possible. This is highly regrettable, but it is not what makes such this particular example morally problematic. Rather, this occurs with the additional neglect (the "forgetting") of the patients' dignity. If that dignity had not been forgotten, and nurses had done their best to take the required samples in a dignifying way, then such treatment would not have constituted a misuse of their power.

Similar considerations apply to the example of Florence, discussed in the previous section. If Florence's mother-in-law was genuinely unable to care for herself at home, then overriding her decision about allowing a live-in carer may have been the correct course of action. But if this was not the case, and alternative arrangements could have sufficed to ensure her continued well-being, then Florence ought to have respected her mother-in-law's decision not to have live-in help. Even if live-in help *was* necessary, however, there may have been other ways in which Florence could have shown respect for her mother-in-law's autonomy, for example by including her in the decision about who to hire and what level of support would be provided.

As previously noted, caregivers often justify their use of power by telling the cared-for that "it's for your own good." We can now see that this sort of justification, whilst sometimes appropriate, is morally risky precisely because it can obscure a failure to achieve the desired balance between the different values to which caring ought to respond. Indeed, in its exclusive focus on caring's *telos*, the thought that "it's for your own good" may even mask a lack of recognition on the part of the caregiver that caring is not just about pursuing a particular outcome but also about the *way in which* that outcome is pursued.

Rather than attempt to draw a firm line between permissible and excessive uses of power, then, care ethicists ought instead to work towards enriching our conception of caring by more fully articulating the values around which care is

oriented. This is not something which is currently taking place to any great extent. On the contrary, the expositions of caring which one typically finds in the literature tend to obscure these different values, based as they are around less cumbersome descriptions of caring which identify it simply as an activity aimed at the meeting of needs. Caring is just such an activity, of course, but it is important to give the fullest possible account of what this activity entails. An important part of such an account ought to relate to the different values which guide caring practices. If a more widespread recognition of these values can be fostered, then the need to balance them against each other may be more fully appreciated, and the risk of the unintentional abuse of power thereby lessened.

### **5. Objections and Replies**

Here, I briefly consider two objections which may have occurred to readers during the previous section. The first of these is that my account depends on an undefended, value-pluralist conception of care ethics.<sup>15</sup> The second is that my proposal simply misses the point about the causes of abuse and therefore does not make the commission of abuse any less likely.

With regard to the first of these objections, let me note at the outset that I do in fact think that a value-pluralist conception of care ethics is both plausible and worth defending.<sup>16</sup> However, my argument in the previous section does not presuppose, nor depend upon the correctness of, this position. To see why, let us suppose that there is in fact just a single value around which caring is oriented, and let us refer to this as the value of need-satisfaction. Does this invalidate my argument? Not at all, for it is highly plausible to suppose that the value of need-satisfaction encompasses not only the need for a sufficiently high quality of life but also the need for dignity, autonomy, and a host of other things as well. In other words, the value of need-satisfaction ranges over each of the goods around which the argument of the previous section was based. Consequently, even if this monistic perspective were true, it would still be possible for me to claim that caring must strike a balance between the cared-for's need for autonomy, dignity, quality of life, and so on.

---

<sup>15</sup> Value pluralism holds that there are multiple, irreducibly distinct types of moral value. This distinctness means that values can sometimes come into conflict with one another, with agents forced to choose between them. Pluralism thus stands opposed to monistic accounts of moral value, such as utilitarianism, according to which there is only one source of moral value (i.e., the promotion of utility). For discussion, see Chang (2015) and Schaber (1999).

<sup>16</sup> I have argued for this claim in Walsh (2018).

To constitute a genuine objection to my account, a monistic approach must argue not only that caring should respond only to a single value but also that the value to which it should respond *does not include* at least three of the goods identified in the previous section.<sup>17</sup> Such an approach might hold, for example, that caring is really only about quality of life, and not dignity, autonomy, or maintaining caring relationships. Now, this would be a genuine objection to my account, and it would be one based on (or at least involving) a rejection of the pluralist aspect of that account. It would also, however, be a deeply counterintuitive objection, requiring a considerable amount of argument against the normative relevance of the rejected values. I take it that such an argument would be unlikely to find many wishing to support it. My argument in the previous section, then, does not rest in any problematic way upon the truth of value pluralism.

I turn now to the second of the objections mentioned above, that is, that my proposal simply misses the point about the causes of abuse. This would be true if I were claiming that all, or most, abuse was the result of carers failing to recognize or respond to some of the values around which caring is oriented. This is not my claim, however. The factors which contribute to the likelihood of abuse are numerous and complex, including drug and alcohol dependency, mental health issues, susceptibility to stress, a perpetrator's previously having been a victim of abuse, and host of other factors. It would be naïve in the extreme to think that a single conceptual issue lay behind each type, and every instance, of abuse. Consequently, my account is by no means offered as a panacea for ending abuse. Indeed, there sadly can be no such panacea.

What I *have* done, however, is to show that even in the absence of each of the risk factors noted above, simply being in a caregiving relationship generates a risk that one's care will deteriorate into the unintentional abuse of power. One of the ways in which this risk can be minimized is by articulating a conception of caring which explicitly foregrounds the various goods to which care ought to be responsive. These goods must be identified explicitly and in detail rather than left at an intuitive level or in the shadow of some more general concept such as need-satisfaction or welfarism. To leave them in the background is to risk overlooking them, when they should in fact be front and centre in our deliberations about how to provide care. A caregiver who is sufficiently attentive to these values, and who takes account of them when considering how to care for those around her, will be less likely to use her power over her cared-for in morally objectionable ways. So, at any rate, I have argued here.

---

<sup>17</sup> I say at least three because it is conceivable that such an approach could reject all four of these goods in favour of a fifth, as yet unspecified, alternative.

## 6. Conclusion

Care and abuse are at opposite ends of the moral spectrum. It is therefore natural to think that when care begins to deteriorate into abuse, the explanation for this must be sought in the operation of something foreign to, or outside of, that care. Power, with its widely recognized potential to generate moral corruption, is often identified as the foreign agent in question. This paper has cast doubt on that assessment.

Imbalances of power should not be seen simply as regrettable features of caring relations, to be minimized whenever possible. On the contrary, the exercise of power over a cared-for is, on many commonplace occasions, a necessary condition of providing good care. So, too, is the willingness to exercise that power, even if doing so will predictably be a cause of distress to the cared-for. It is this feature of caregiving, rather than the presence of power itself, which creates the risk that care will deteriorate into abuse. The risk of abuse, that is, stems not from the mere presence of an imbalance of power but from the very nature of caregiving.

Because this risk of power abuse is a product of care itself, it is not something which can simply be annulled by some fancy philosophical footwork. It can, however, be mitigated. One of the ways in which to begin to do this is to recognize explicitly the nature of that risk, as I have tried to do in this paper. Another way is to engage in closer critical reflection on the nature of caring itself and the values around which care is based. By trying to strike a balance between each of these values, it is to be hoped that our pursuit of the ends at which caring aims will be both informed and restrained by, among other things, a concern for the dignity and autonomy of the cared-for.

## References

- Banks, Sarah. 2016. "Everyday Ethics in Professional Life: Social Work as Ethics Work." *Ethics and Social Welfare* 10 (1): 35–52.  
doi:10.1080/17496535.2015.1126623.
- Barnes, Marian. 2012. *Care in Everyday Life: An Ethic of Care in Practice*. Bristol: The Policy Press.
- Bloom, Paul. 2016. *Against Empathy: The Case for Rational Compassion*. London: The Bodley Head.
- Bubeck, Diemut Elisabet. 1995. *Care, Gender and Justice*. Oxford: Oxford University Press.
- . 2002. "Justice and the Labor of Care." In *The Subject of Care: Feminist Perspectives on Dependency*, edited by Eva Feder Kittay and Ellen K. Feder, 160–185. Lanham, MD: Rowman and Littlefield.

- Chang, Ruth. 2015. "Value Pluralism." In *International Encyclopedia of the Social & Behavioral Sciences*, 2nd Edition, edited by James D. Wright, Volume 25: 21–26. Oxford: Elsevier.
- Collins, Stephanie. 2015. *The Core of Care Ethics*. Basingstoke: Palgrave Macmillan.
- Coulter, Angela, and Alf Collins. 2011. *Making Shared Decision Making a Reality: No Decision about Me, without Me*. London: King's Fund.
- Engster, Daniel. 2007. *The Heart of Justice: Care Ethics and Political Theory*. New York: Oxford University Press.
- Eriksson, Catharina, and Britt-Inger Saveman. 2002. "Nurses' Experiences of Abusive/Non-Abusive Caring for Demented Patients in Acute Care Settings." *Scandinavian Journal of Caring Sciences* 16 (1): 79–85. doi:10.1046/j.1471-6712.2002.00061.x.
- Friedman, Marilyn. 1987. "Beyond Caring: The De-Moralization of Gender." *Canadian Journal of Philosophy* 17 (S1): 87–110. doi:10.1080/00455091.1987.10715931.
- Held, Virginia. 2006. *The Ethics of Care: Personal, Political and Global*. New York: Oxford University Press.
- . 2010. "Can the Ethics of Care Handle Violence?" *Ethics and Social Welfare* 4 (2): 115–129. doi:10.1080/17496535.2010.484256.
- Kittay, Eva Feder. 1999. *Love's Labor: Essays on Women, Equality, and Dependency*. New York: Routledge.
- Meyers, Diana T. 2004. "Narrative and Moral Life." In *Setting the Moral Compass*, edited by Cheshire Calhoun, 288–305. New York: Oxford University Press.
- Miller, Sarah Clark. 2012. *The Ethics of Need: Agency, Dignity, and Obligation*. New York: Routledge.
- . 2017. "Reconsidering Dignity Relationally." *Ethics and Social Welfare* 11 (2): 108–121. doi:10.1080/17496535.2017.1318411.
- Mullin, Amy. 2011. "Gratitude and Caring Labor." *Ethics and Social Welfare* 5 (2): 110–122. doi:10.1080/17496535.2011.571061.
- Noblit, George W. 1993. Power and Caring. *American Educational Research Journal* 30 (1): 23–38. doi:10.2307/1163187.
- Noddings, Nel. 1984. *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley: University of California Press.
- . 2002. *Starting at Home: Caring and Social Policy*. Berkeley: University of California Press.
- Phillips Judith C. 2007. *Care*. Cambridge: Polity Press.
- Prinz, Jesse. 2011. "Against Empathy." *Southern Journal of Philosophy* 49 (S1 Spindel Supplement): 214–233. doi:10.1111/j.2041-6962.2011.00069.x.

- Pyke, Karen. 1999. "The Micropolitics of Care in Relationships between Aging Parents and Adult Children: Individualism, Collectivism, and Power." *Journal of Marriage and Family* 61 (3): 661–672. doi:10.2307/353568.
- Ruddick, Sara. 1995. "Injustice in Families: Assault and Domination." In *Justice and Care: Essential Readings in Feminist Ethics*, edited by Virginia Held, 203–223. Boulder, CO: Westview Press.
- Schaber, Peter. 1999. "Value Pluralism: Some Problems." *Journal of Value Inquiry* 33 (1): 71–78. doi:10.1023/A:1004377115243.
- Sevenhuijsen, Selma. 1998. *Citizenship and the Ethics of Care: Feminist Considerations on Justice, Morality and Politics*. New York: Routledge.
- Slote, Michael. 2007. *The Ethics of Care and Empathy*. New York: Routledge.
- Tronto, Joan C. 1989. "Women and Caring: What Can Feminists Learn about Morality from Caring? In *Gender/Body/Knowledge: Feminist Reconstructions of Being and Knowing*, edited by Alison M. Jaggar and Susan R. Bordo, 172–187. New Brunswick, NJ: Rutgers University Press.
- . 1993. *Moral Boundaries: A Political Argument for an Ethic of Care*. New York: Routledge.
- Walker, Margaret Urban. 1989. "Moral Understandings: Alternative 'Epistemology' for a Feminist Ethics." *Hypatia* 4 (2): 15–28. doi:10.1111/j.1527-2001.1989.tb00570.x.
- Walsh, Joseph P. 2018. "Caring: A Pluralist Account." *Ratio* 31 (S1): 96–110. doi:10.1111/rati.12179.
- Weinstein, Carol S. 1998. "'I Want to Be Nice, But I Have to Be Mean': Exploring Prospective Teachers' Conceptions of Caring and Order." *Teaching and Teacher Education* 14 (2): 153–163. doi:10.1016/S0742-051X(97)00034-6.

JOSEPH WALSH completed his PhD at the University of Kent in 2013. He researches the ethics of care and virtue ethics, and is currently working on the normative significance of commitment and what this means for caregiving. Recent publications include "Commitment and Partialism in the Ethics of Care," *Hypatia* (2017); "Caring: A Pluralist Account," *Ratio* (2018); and "Care, Commitment and Moral Distress," *Ethical Theory and Moral Practice* (2018).