Careful Thinking Episode 5 Transcript

[00:06] **Martin Robb:** Hello and welcome to this episode of *Careful Thinking*, a new podcast exploring ideas about care. I'm Martin Robb, and I'm the host of the podcast. *Careful Thinking* is inspired by a belief that thinking critically about care can both deepen our understanding and help to improve the day-to-day practice and experience of care. In each episode of the podcast, you'll hear an in depth conversation with a writer, researcher or practitioner at the cutting edge of current thinking about care. My guest for this episode is Ruth Groenhout. Ruth is a distinguished professor of healthcare ethics in the Department of Philosophy at the University of North Carolina at Charlotte in the United States. Her primary areas of research in healthcare ethics have focused on issues of gender, health systems and organisations, and health policy. Ruth has published widely on care ethics, bioethics, feminism and faith. Her many books include *Connected Lives: Human Nature and An Ethics of Care*, published in 2004, *Bioethics: a Reformed Look at Life and Death Choices* from 2009 and *Care Ethics and Social Structures in Medicine*, which came out in 2019. And as always, I'll put full details of Ruth's publications in the show notes for this episode. I first came across Ruth's book *Connected Lives* when I was just beginning to be interested in care ethics, and I've found it one of the most accessible and thought-provoking introductions to the subject, and one I'd highly recommend. More recently, Ruth and I were both contributors to an edited collection on *Care Ethics, Religion and Spiritual Traditions*. And on a personal level, Ruth's writings on the connections and tensions between religious faith and feminist care ethics have really resonated with me. So I'm really pleased to have the opportunity to discuss Ruth's work with her in this episode. So Ruth, a very warm welcome to the podcast.

[02:10] **Ruth Groenhout:** Well, thanks. It is wonderful to be here and I'm looking forward to this.

[02:14] **Martin Robb:** So a general question then, to start off our conversation. How did you, as a philosopher, come to be researching and writing on healthcare and care ethics? So maybe you could tell us something about the trajectory of your academic career and how your interest in care ethics developed?

[02:30] **Ruth Groenhout:** Sure. Essentially, I started out with medical ethics as what I was really concerned with as an undergraduate. I was a joint pre-med and philosophy major, and it was sort of 50/50 which way I would go. And then sort of ridiculously, I hit the ontological argument and it was just so exciting and so much fun to, I don't know, work through in some ways that I was okay, okay, philosophy. But I had worked in healthcare and had connections. And when I got to grad school, because I was interested in that, I got on to a medical ethics committee. So that was a very natural place for me to be to be interested in. It's also a great place for someone who is interested in the connection between theory and applied ethics. A lot of people do one or the other. They do the theory, or they do the applied ethics. I kind of like the juncture between them. How does theory affect things? And then when I was in graduate school, there was no discussion, really, of much of feminist thought at all at the University of Notre Dame. But you know how grad students are. I was wandering through the stacks in the library in the ethics section, and I happened to see this pink book, said, *Caring*, and I thought, oh, that looks interesting. Grabbed it, threw it on top of the stack that I was checking out. And then I had to run to class after I got these books. And so I have a

stack of books with the *Caring* on the top. And my professor walked into the classroom, pointed at that book, and said, there's no point in reading that. I mean, there's just nothing there. And I said, oh, I mean, when did you read it? What in it is stuff you don't like? And his response was, oh, I didn't have to read it, you know, I just knew it wasn't worth reading. And I've always been a little oppositional, so to read it. And I had three kids in grad school, and so reading Nell Noddings' discussion of women's work and the way that ethics doesn't always make any sense at all in the context of women's work, it really resonated with me. And so Noddings has been one of those people that I don't always agree with, but has been important for getting me into care ethics. And I did get a chance to meet her a couple of times, and - just a lovely person. Yeah. So that was how I got into care ethics. And then once I did, it fit so well with medical ethics because healthcare is about care, so it's just been a natural fusion between the two.

[05:08] **Martin Robb:** That's interesting. And, yeah, reading *Connected Lives*, I thought it felt like a dialogue that you were having with Nell Noddings all the way through. So she's obviously been an important influence for you.

[05:20] **Ruth Groenhout:** Yeah.

[05:20] **Martin Robb:** So you mentioned feminism, and I just wonder whether it's fair to say that feminism and Christian faith and maybe the connections or tensions between the two have been kind of the two key intellectual influences on your thinking about care. Would that be fair to say?

[05:38] **Ruth Groenhout:** They're certainly both running strongly in the background. One of my early works - I was at the Erasmus Center at Notre Dame, and I wrote a piece called 'Theology in an ethics of care'. And there are some - Noddings herself worked off of Buber quite a bit. So quite a bit of Jewish thought was going on in terms of some of those theological concerns. But there's also a long history of Christian theology making love the centre of things. I mean, it's supposed to be so important. So when you move into care, there's a sort of natural connection between care and love, I think.

[06:16] **Martin Robb:** Interesting. Thank you. Now, in my previous episode, the previous episode of the podcast, my guest Petr Urban commented that Maurice Hamington's ground breaking book on *Embodied Care* is celebrating its 20th anniversary this year. And of course, that's also true of your equally important book *Connected Lives*. So if I can ask you to cast your mind back two decades, how did you come to write that book, and what were you hoping to achieve in writing it?

[06:43] **Ruth Groenhout:** I came to write it because my mind was working through both care ethics and thinking about healthcare. But the other thing was, because I'd worked on the connection between theory and applied ethics, I was beginning to think, okay, so how do you think about care ethics? Not so much in terms of personal relationships, relationships, but in terms, as a matter of fact, of whole practices. I also come from a background where I've worked a lot in virtue ethics. And so it seemed to me there were some interesting overlaps between care theory and virtue ethics. And in particular, I wanted to look at the

notion of human flourishing, because I think caring is one of the essential aspects of flourishing, and that became part of that text as well.

[07:29] **Martin Robb:** And in your introduction to the book, you're quite critical of the kind of dominant tradition of western philosophy coming down from Aristotle, which emphasises rationality as the core of what it means to be human. Can you perhaps summarise that critique and say how a feminist ethics of care offers an alternative to that tradition?

[07:51] **Ruth Groenhout:** Yeah, I think, interestingly, there's been a long history in western thought about either saying, humans are human because of their intellect or because of their emotional, relational sense of who they are. David Hume actually always gets sort of brought up in this context. And while I don't like everything Hume ever said, there is something about starting from emotions rather than starting from the intellect. Now, here I actually kind of went back to Aristotle more than to Plato, because for Aristotle, the emotions actually are a central part of the intellect, and they can't function. The intellect can't function without, without emotions. So it always seemed to me that there was, but there was something important about starting with the emotions. It's also the case that, especially as I've developed further along in philosophy and working in medical ethics, that one of the things that concerned me was the way that children, folks with disabilities, elderly folks who suffered dementia or whatever, they tended to get pushed out of the human category altogether. In Kant, for example, they almost become not human, especially at the end of life when rationality is not going to come back. And that seemed deeply wrong. And so the emphasis in care, on caring, relationality as part of what it is in a central part of what it is to be a human being, really resonated with me.

[09:27] **Martin Robb:** Yeah, that's interesting. I had a similar conversation in an earlier episode with Xavier Simons, and we were talking about Eva Feder Kittay, writing about her own daughter, severely disabled, and, you know, really locating her humanity in her ability to form relationships rather than rationality. So that was really interesting. So you've mentioned Nell Noddings, and in the book, one of the useful things you do, as I say, it's a really good introductory text, because you provide a kind of potted history of feminist care ethics, and you run through some of the key names and texts. I wonder, besides Nell Noddings, who have been the feminist writers on care, who have influenced you most personally, who are the real touchstones for you?

[10:10] **Ruth Groenhout:** Yeah, that's such a great question. The two that I would probably initially bring out would be, as a matter of fact, Eva Feder Kittay, who's just been really influential in my thought and as well as Joan Tronto. And I think Joan Tronto was so important because, coming a little more out of political theory rather than standard philosophy, she was very interested in how relationality affected whole practices and policy and legal structures. And that resonated with me, probably because of my background in virtue ethics, I think. But that basic notion that, yeah, it's not enough to talk about interpersonal relationships. You really do need to talk about how the policies and the social structures are set up. And again, that also goes back to feminist thought. If we limit it to personal relationships, women have been - sort of had personal relationships dumped on them for huge chunks of time. Not just women, other minority groups as well. But it does seem really important to think about what kind of policies should we talk about with care.

And so with Joan Tronto, starting with elder care, was just, I mean, it was lightbulb-inducing. It was great. Yeah. So that, and then Eva Feder Kittay knowing sort of where she's going with some of these things and seeing how she develops relationality. I should probably add one more thinker, and that would be Sarah Ruddick, who doesn't always get identified as a care theorist. But her willingness to take mothering practices and think about how that affects epistemology, I think was actually quite important in that it's not just, I don't know, are we nice to each other? It really is how you think in some ways that your practices in life make sense. And that one fed into one of my concerns, which was, if care is only women's work, and to some extent, that's where Noddings started, I think that was appropriate, but you can go overboard on that. If care is really essential to human life, then excluding men from caring relationships should worry us almost as much as for forcing women to do big chunks of them, because you're missing one of the central aspects of human life altogether. And that strikes me as problematic.

[12:34] **Martin Robb:** Now, it's a feminist book, but you choose to focus most of your discussion on two male authors, St. Augustine and Emmanuel Levinas. So some might think them a curious choice for a book about feminist care ethics. So what made you decide, again, if you can think back 20 years to when you were writing the book, what made you decide on those two male thinkers as the focus for the book?

[12:56] **Ruth Groenhout:** My guess is part of it was I had just gotten out of the University of Notre Dame, which is a very historical program, so you kind of have to go back in history. Right. But the other thing is that both of them are important thinkers. For me, Augustine is one of those people - I think of certain philosophers as people I can't walk away from. Doesn't mean I agree with them. It's just I keep finding myself in conversation. And Augustine definitely falls in that category for me, partly because I do come out of the reformed Calvinist tradition, and Augustine is central for that. I've taught the *Confessions* in an awful lot of intro courses, have worked through so many works by Augustine, and there's some real strengths there, some really important issues, and then also stuff I can't stand. And so that combination. But what I really wanted to focus on was Augustine really does think that God truly is love. We are made in God's image, and so we are created to love, which sort of makes love or care an absolutely central part of what you think about. Also, he does have, I think, an important analysis of when love goes wrong, which is when we love things that are not important, as if they were central to our lives. We make deep, deep mistakes. And I do think that's a helpful way to move towards care - is that, yeah, I mean, we really do - care really is central to human life, but it's also very easy to start caring about how wealthy we are. It becomes very easy to start thinking about caring in ways that really undercut the caring relationality that I think is so central to human life. So I found Augustine helpful. He goes in problematic directions, likewise Levinas. He really wants to reject a sort of simplistic rationality and move in the direction of just the gaze of the other pulls us into an essence relationship and his totality in infinity in particular, where he separates out the notion of defining somebody else as who they are versus recognizing that they're really, they're not us. And we have to be listening to them and learning from them when we're in that ethical relationship. I actually think he goes just a little bit too far. The infinite other doesn't make sense in caring. If you're dealing with a small child, particularly, you need to be able to recognize that even if they can't speak yet when they whack their head, it hurts, you know, if you can't sort of move beyond absolute totality to, no, we actually are humans

and we have a lot in common. I think the same is true for an awful lot of the whole mammals group. You know, that we actually can understand a lot of what the other is experiencing, but that doesn't take away the recognition that they're, they're different. I've got to actually learn them instead of defining them on my own terms.

[15:57] **Martin Robb:** Yeah, you kind of anticipated my next question about Augustine, but yeah, because I was going to say that particularly through the Calvinist tradition, he's often probably mischaracterized as having a very negative view of human nature after the Fall. But you identify this sort of more positive aspect, viewing human beings as innately loving or having a capacity, love. So I found that refreshing reading that, because it kind of undermines that stereotype of him. But you also identify some dissimilarities between his thought and feminist care ethics. And you also say there's some things that he maybe supplies that may be missing from contemporary care ethics. And one of those is an understanding of evil, which you hinted at just now, I think. And you write, 'care theory needs an account of the source and nature of evil'. So do you think care ethics sometimes has too rosy and utopian a view of human nature?

[16:51] **Ruth Groenhout:** I think it can, yes. And that was one of the things I was a bit worried about with some of Noddings' early thought. Now, she did write a whole book on evil, which was quite different. But in her first book, *Caring*, it did sort of seem as though anytime you were caring, you were being a nice person. So that was good. And yet we've seen care go deeply, deeply wrong in a lot of cases where somebody cares, cares, and they have good intentions often, but what they do to another person is extraordinarily problematic, and the other person seems to have no voice back. Again, one of the things I appreciate about care is it recognizes power dynamics. And it started off pretty early doing this, recognizing that quite often caregivers have a lot more power than those for whom they care. Not always, but quite often. But that power should come with a certain amount of being very cautious, because it makes it very hard for the other to say, I don't want you to care for me, stop it, or something along those lines. They're shifting the way we understand care. It does seem to me that care theory needs to be quite cautious about, yeah. Whether or not it thinks caring is always nice. Moving into the healthcare context, this is really vital, because when I started doing healthcare, one of the standard things we had to teach was, is it okay for doctors to lie to their patients? And there were huge numbers of physicians who said, oh, that's an essential part of how we do things. Particularly when people are facing death, we don't want to tell them that they're, you know, they're in that sort of condition. And when you talk to patients, they said over and over again, I need to know. Now, not everyone, but 90% of them want to know what's coming down the tracks so they can, you know, get their family members involved or even, you know, repair relationships that haven't been good ones. And that's so crucial for patients also just going out and getting your will updated – simple - that's not simple, but really straightforward things. People do need to know what their actual condition is. And yet this was very caring on the part of the physicians. They wanted to do a nice thing to their patients. And so that kind of power dynamic, coupled with concerns about care that really are not the concerns that the one cared for is going to benefit from on their own terms. And again, the Levinas stuff is quite helpful here, remembering that, no, I don't get to decide who that person is. They really are who they are.

[19:28] **Martin Robb:** That's right. And I'm particularly interested to talk to you about Levinas because he was an important influence for another of my earlier guests, Nigel Rapport, and he's writing a book about him. And, you know, as with Augustine, you focus on relationality, embodiment, and particularity in Levinas's writing, and you've always already mentioned his emphasis on otherness and the unknowability of the other person. But you link that to a sense of the sacred, which is interesting. I found that interesting. And you say that's something that maybe he can contribute to care ethics. So what's the link between the other being completely other and the sacred?

[20:09] **Ruth Groenhout:** Traditionally, of course, that was part of early debates in the medieval era about whether we could know God, or whether the closer we got to God, the less we knew about God, because God was so, so different. And that was both the Jewish and the Christian tradition in certain ways. So that's one of the early connections to why otherness would be connected with the sacred. Also going back to Augustine, recognizing that the other, to some extent, bears the very image of God, if you couple those two together, you do get this picture that the other must be treated with respect and love. But I don't know who the other is. And so the only way to really do that is to get to know the other. And relationality requires that sort of a relationship. I think that was particularly what made me interested in that sort of issue. But the one thing I would add to that, I guess, is that, again, working in healthcare ethics, I do think it's very important for medicine to allow patients to tell their own story, to be who they are. And particularly because I often worked in Catholic healthcare systems, they would actually couple that with the notion of the image of God, that there was something sacred about each patient that caregivers worked with, and that each patient really did bring their own story. And there's almost something, it's not something to be worshipped, but there is something to be respected and listened to and to learn from in each other that you find yourself working with.

[21:46] **Martin Robb:** So, moving on from Augustine and Levinas, in the next chapter of *Connected Lives* on human nature, you take up the argument that care ethics is situationalist, and you argue that instead, because it focuses on an ideal human flourishing, there is a kind of ethical norm at the heart of care ethics. You suggest that care theorists are committed to the centrality of care, reciprocity and interdependence as central aspects of a flourishing human life. Is that enough as a guide to ethical action, do you think?

[22:20] **Ruth Groenhout:** I don't think anything is enough as a guide to ethical action. One of the things I did love about one of the profs that taught me about ethics in grad school was the claim. and it wasn't unique to that professor, but that if you have a really complicated, difficult question and you give a simple answer to it, you're wrong. It's, you know, and this is one of the concerns about utilitarianism, you take these really, really difficult and complicated questions and you say, oh, just add up the numbers and you'll get an answer. That should worry anyone who thinks about it. That's not where we should go. So I don't think there's any ethical theory that absolutely resolves things. And this is where I would go back to a little bit, to Aristotle and the notion of practical wisdom, that if you're going to be talking about actual practical issues, you have to realise that they shift almost every time. You know, you're dealing with different people, you're dealing with a different context, and you're trying to get the best answer you can. Now, in healthcare, one of the standard things that gets said all the time is the perfect is the enemy of the good. And I think that's worth

hanging on. In care ethics is the notion that, no, don't look for a perfect answer for everything. The answer that resolves, you know, the, the ring that will bring the totality of power. No, it's never going to give you that. You always have to work through particular questions. You always have to think about these sorts of things. So I don't think care ethics is ever going to give us absolute answers. But again, thinking about medical ethics, I do think there are some limits that we should set up now in care ethics. Early on, they had this big debate between care and justice. And for some people, there's care or there's justice. Never the twain shall meet. And so they had to fight that issue out. I've always gone with both Joan Tronto and Virginia Held, who have argued that, as a matter of fact, you can't really adequately care if there aren't some basic constructions of justice in place. Yes, people try to parent their children really well under horrendous circumstances. They're undercut at every possible point. So while they're trying to produce care, the lack of justice makes it almost impossible. But at the same time, if all you have is justice but no care, then as a matter of fact, you have a very hard, cold, ultra-Kantian system that really can never do what it needs to. I think both of those are very true. In medical ethics, yes, we need to respect patient autonomy. Sorry, but patient autonomy isn't just getting a signature on an informed consent form. It really does require sitting down and getting to know who you're talking to, what their concerns are, limitations are what, what they may not even understand about the particular procedures that are being recommended. You've got to have both care and justice in medical ethics, or it goes very wrong.

[25:24] **Martin Robb:** Now, in the final two chapters of the book, you turn to the practical application of care ethics to contemporary issues in healthcare, new reproductive technologies and cloning. And you already said that what you like about Joan Tronto's work is that not being willing to confine care ethics just to interpersonal relations or interpersonal care, but arguing that it can make a contribution to these big public questions. So what exactly can a care ethical approach contribute to the debate, for example, about assistive reproductive technologies?

[25:57] **Ruth Groenhout:** Yeah, that's one of those really interesting questions that still, I mean, here in the US, if you're familiar, there was just a law that looked like it was going to ban IVF altogether in Alabama, and that's still hugely under debate when things go on. But one of the things that rarely gets pointed out about IVF is that it's technology that is on the borderline between business and healthcare, at least here in the States. It functions differently, obviously, in different countries, and it's treated in certain ways as a consumer product. So people are purchasing this. And of course, in a capitalist system, purchasing is ‘buyer beware’. But many of the IVF programs have actually refused to do long-term studies about what sorts of dangers there may be, whether there are, you know, statistically problematic aspects, either to the parents involved, particularly the woman's body, which gets treated interestingly, or the child who actually is produced by IVF. And I think I did mention this in the book, it was fairly early then. It's become much more common. One of the issues that they're using in IVF, just almost universally, is that if a husband's sperm doesn't seem to be working to fertilize eggs, what they'll do is inject the sperm. It solves that problem. What they're not looking at is the question of whether, evolutionarily, we humans have gotten to a point where maybe the eggs and sperm that don't want to join, there's a reason for that we don't know. And that might be something we'd want to know before we use that technique to create, you know, human beings who are going to have to live with

whatever comes down the pike, and we're not studying it. We don't want to know what, you know, whether ten years out or 20 years out, we're seeing statistically some concerning issues with this technology, and that's one of the simpler technologies that we're using.

[28:02] **Martin Robb:** So those two debates kind of form a nice link with your more recent book, I think, because your 2019 book is called *Care Ethics and Social Structures in Medicine* And it takes up some of these still resonant issues around technology, for example, in healthcare. So again, with this book, can you just give us an overview of what the book's about and what your main argument was?

[28:25] **Ruth Groenhout:** Sure, the book was one that really does click back into that notion that care theory does need to be able to talk about policies, about social structures, about those sorts of things. And in healthcare, in medicine, I argue that the best way to do that, and I think this applies in other areas, but that's my specialization, the best way to do this is not to turn everything to personal relationships, but instead to look at how social structures affect the way that caring relationships become even possible. Because we can talk about social structures that make it almost impossible - we can talk about social structures that allow it but don't really help it, and then we can talk about social structures that really, really do assist caring relationships. And so in healthcare, that's a great thing to think about. And it's also fairly straightforward to know that many of the policies, and here I'm talking mostly about US healthcare, because that, again, is the area I know the best. But American healthcare has seen actual personal relationships as the easiest thing to cut to save money that you possibly can. Nurses are very, very, very well trained in holistic healthcare. So they know how to talk to their patients about their religious beliefs, their spiritual life, their connections to all these sorts of things. But they're so limited in time these days. Our nursing, the number of nurses in a healthcare system have been cut to such a degree. They literally walk in and out of patients' rooms to give medicine and then fill out the forms. Sitting over there to actually sit down and talk to a patient who's just gotten a diagnosis of cancer, they don't have time for it. And their insurance makes sure the insurance companies make sure they do not spend the time, because that's seen as a waste of money, and that is leading to huge amounts of burnout on the part of nurses. And it makes caring relationships - either they put the woman, sorry, not the woman, the nurse's career, at risk, literally, or as a matter of fact, you have to just refuse to care. Walk in, walk out, don't talk to your patients. Hardly know their names. We should not be having structures like that in healthcare. So time is one of the easiest ones or not easiest, but it's one of the most important ones to talk about when we talk about these things. So I think that's vital.

[30:50] **Martin Robb:** And again, on an earlier episode, I remember we had a conversation about how spiritual care should not be marginalized to chaplains. You know, that in a sense, as you're saying, you know, the frontline health practitioner has a role as a spiritual carer as well as a carer for the body, and that gets marginalized by budgets and lack of time, doesn't it? So in the book, you provide a critique of evidence based practice, and you talk about its limitations from a care ethical perspective. Can you say a little bit about that?

[31:22] **Ruth Groenhout:** Yeah, I think evidence based practice, by the way, is a very, very good thing. Thing. There's a lot of strengths to it. I really do think basic scientific evidence is very handy for medicine, and we really should pay a lot of attention to it. So this wasn't a

reject evidence based practice, but I do think there are some concerns, and one that care brings up is that evidence based practice can use its research to look at evidence of very sorts of, certain types of practices really, really well. So if you give some patients this medication, some patients that medication, we can get the statistics, we can get a very good sense, and then we can even these days, say, when there's genomic differences between the patients, different medications might work better. It's wonderful for that sort of thing. But one of the things I talked about was pain control. And we know that some medications work pretty well for pain control. But do we know how much caregivers sitting down and working with a patient on some psychological attempts at pain control work? One of the problems with studying that is that it's not like a pill where every pill is exactly the same. Different caregivers are better and worse at actually giving that kind of training, working with patients, listening to the patient about what, as a matter of fact, they may need for pain control. And so there's lots of things we know can help with pain control. Even straightforward things like certain breathing exercises can help you come to terms with pain that don't need medication necessarily. But who taught you those techniques may make a huge difference. And evidence based medicine doesn't have a good way of studying that because it really is particularistic and individualized, and that's exactly what they can't study in evidence based measures.

[33:15] **Martin Robb:** Sure. Now, you've already mentioned the economic pressures that health care providers are under, particularly these days. And in one of your chapters in the book, you discuss the economics of healthcare and you review different models, not just the US market based system, but state regulated insurance models and the public health model, which we're more familiar with from this side of the Atlantic. But you conclude that there's no utopian solution to the economics of healthcare. Do you think an ethic of care points to one kind of system being at least marginally preferable to others? Or are there some core ethical principles that any kind of health system, whatever the economics behind it, should espouse?

[33:57] **Ruth Groenhout:** Actually, I think both of those. I do think healthcare should always espouse meeting the basic needs of basically everyone who, who needs healthcare in that either geographical region or that country. That seems to me to be one of the basics of healthcare. I do think both government authorized insurance systems, I think the Netherlands has a classic one, and national health systems can be really, really helpful in terms of making sure that healthcare is provided at a decent level to everyone who needs it, which I think is essential to care. But both of them, are always a little bit at danger if you have individual insurance companies that are not completely regulated by the government. The government can't all of a sudden decide it doesn't want to pay for it, wants to have them not bother to pay for certain things. I think the UK right now is facing issues because there's political differences about how much the National Health Service really should be subsidized. Honestly, I would be worried about that. And I think it's very problematic to cut health care in some of the ways that it's been cut. But I don't want to jump into another country's politics right now. But so neither one of them is an automatic answer. And there are some weaknesses that I think we have to be aware of. But I do think both of those systems overall tend to meet the requirements of care at a higher level.

[35:29] **Martin Robb:** There seems to be a thread of pragmatism running through your work. I like the fact that you reject sort of utopian solutions, or the fact that there might be a utopian solution to some of these thorny issues. So that's really nice. Now you end the book, the 2019 book, with a discussion of end of life care and some of the ethical dilemmas associated with it. And I just quote a bit. You say 'no ethical theory can make the end of life uncomplicated or easy'. Your pragmatism again. 'But an ethics of care does offer a perspective from which we can see why some of the complications arise, what can be done to mitigate them, and how we might approach the various issues in ways that provide a more caring, less conflicted context for dying patients.' And you share some examples from different parts of the US which are more positive. Perhaps maybe you could just share a couple of those here. And also, you focus quite a bit on hospice care. So do you see hospice care as embodying particularly well, a care ethical approach to end of life care?

[36:30] **Ruth Groenhout:** I'll start with that last question first. Yes, I do. Again, it's not perfect, and there are places where hospice has not worked particularly well for a variety of reasons. But I would say the vast majority of hospice care has been enormously important. It moves patients away from being seen as sort of physical objects that need really aggressive care into a much more relational situation. So hospice care really does offer a recognition of the importance of relations. Hospice workers are trained in setting up both pain control that allows the person to continue on with their relationships, rather than pain control that automatically puts people almost into a comatose shape, and then encouraging those relationships insofar as that's possible as a person is going through their procedure. But one of the ironies I find about hospice is some of the early studies wanted to see how much sending people to hospice, rather than aggressive care, actually shortened their lifespan. The study stopped, at least one of the studies stopped about halfway through, because the effects were opposite, actually, patients who were getting really aggressive care. And if you think about this, on very weak and very elderly bodies, in most cases, they were actually dying sooner than some of the hospice patients who were just getting pain control and then as much support as they could be given. But now hospice has been tremendously important. We can then contrast that a bit with moves towards aid in dying, assistance in dying that has been going around the world in a certain way and getting debated in lots of different ways. And again, I think there's some important aspects of here. I'll go back to the Levinasian language that I was using before of really seeing patients as the other. I'm not sure we should determine for patients which of those answers is the right one for them, and tell them in advance, no, you're not allowed to do this, you must do that one. It strikes me that for some life stories, the choice to end one's life, when you know you're in the process of dying and you've got very strong reasons for saying, and I want to be the one who decides when that dying happens and with whom and in what location, that for some folks, that is the right end to the story of their life. At the same time, hospice has a way of allowing people to live longer and, you know, have those long, drawn out conversations with the people they love in ways that can be really important. I think both of those should be available to patients, quite honestly.

[39:20] **Martin Robb:** Yeah. As you say, it's a very hot issue at the moment, particularly in countries like Canada, but also in parts of Europe as well. I realized I forgot to ask you a question about one of the earlier chapters, but maybe I can frame it in - in terms of what you've written about hospice care, because I forgot to ask you about the chapter on power

relations in healthcare. But one of the examples you give, which you kind of quote as a more hopeful sign, is the efforts of some patient groups, or the success some patient groups have had in changing policy. And one of the examples you give, well, you argue that hospice care, to some extent, has spread or come about because of campaigns by patient groups around the right to die, which I thought was quite an interesting, perhaps controversial view. So maybe say something about the power that maybe patients have to change healthcare policy or healthcare attitudes.

[40:14] **Ruth Groenhout:** Yeah, I think that is - and I think the other thing is that power often does come from caring relationships. So it's worth remembering that when you think about care, that there's a power to care that's worth thinking about. Because it wasn't just patients who fought for assistance in dying. It was, as a matter of fact, their families, their loved ones, who were watching them go through really painful, horrendous experiences and knew that that was not what was appropriate for their family member and their loved one. And so they started fighting for the right to, as a matter of fact, end their lives when they were already terminal. And as a matter of fact, they knew there was no sort of happy way out of this, and they wanted to control the way they passed. Yeah, there's some pretty good historical - and I'm sorry, I can't just do it off the top of my head, but there's some pretty good historical evidence that prior to the right to die movement, medicine saw its goal as extending human life. And so it was always aggressive care right to the end of life. And if you even look at the attempts here, now here in the States, the attempts by patients to say, I should have the right to say, turn my ventilator off or stop getting too intubated for various things, and the healthcare system was saying, no, no, that's treatment that we have decided is important for you, you must have it. And patients had to fight for that as well. And so, yeah, I think it was the right to die movement in many ways. And the success that it was getting, that did make the healthcare system go, oh, maybe we're not doing as much to help people as we thought. And the families and the folks who were fighting for that, as a matter of fact, did have some power in the whole system to say, as a matter of fact, you do need to be listening to your patients. They have important things to say. And that did make hospice possible. And I think that was a very important move here. I guess we're getting a little Hegelian that sometimes the antithesis is what moves us to a synthesis, and that we shouldn't always be happy with having an answer that we think is the final answer to everything. It's good to hear people who disagree with you once again.

[42:25] **Martin Robb:** Absolutely. Yeah. And I found that a very thought provoking alternative history of hospice care. Okay, so finally, I think, Ruth, to bring you full circle to where we began and to the relationship between Christian faith and faith and care ethics. I mentioned at the outset the chapter that you contributed, the very first chapter in that collection on care ethics and spiritual traditions. And you give the chapter the title, ‘Care ethics and forgiveness, lessons and errors from the Christian tradition’. And in the chapter you write, ‘just as forgiveness is crucial to care ethics, is also crucial to a Christian ethics of love’, so maybe this is another point of connection between faith and feminist care ethics. And if that's so, what lessons can care ethics learn about forgiveness from the Christian tradition, but also, what errors from that tradition does it need to avoid?

[43:14] **Ruth Groenhout:** The first lesson, I think, is how important for relationships of love or care forgiveness is on both ends. That I forgive you, you forgive me, and we each actually

learn to forgive ourselves. If we just take, again the caregiver patient relationship with - for thinking about that, I would say there are no caregivers who haven't made errors. Sometimes they're tired, they're working with huge amounts of patients. They have to go in, and sometimes their time is so limited that they really have to work quickly. Things aren't always perfect. They don't come out right. And I do think it's okay for a caregiver to say either to the patient or to the family, I probably didn't make the best decision there, I apologize, or I didn't explain it well enough, or I mean, these sorts of things. And to be able to say that actually makes the relationship a better one, a stronger one. But I think the patient sometimes can be pretty awful to the caregivers, as a matter of fact, and can, you know, accuse them of attacking them and these sorts of things. Again, I think it's healthy for a patient to say, I'm sorry, you know, I was dealing with so much stress and anxiety, really sorry with how I came at you last time, I do trust you, let's work on this relationship. So forgiveness on both sides, I think, can be extraordinarily important. And also forgiveness of oneself. When you make a mistake and you're a perfectionist, like a caregiver is, it is so hard to say, I screwed up. It's okay. I'm still going to walk back into the, you know, into the surgery and do the next one. Mistakes happen. It doesn't mean it's okay. It just means I can forgive myself. So I think that comes out of the Christian tradition and I do think it's very important. But it's also the case, the Christian tradition has misused, has misused forgiveness, and particularly when the powerful are allowed to demand forgiveness from the more vulnerable. And we've certainly seen this in the sex abuse scandals from a number of different religious traditions. But when they can demand forgiveness in order to prevent any accountability, that's absolutely horrendous. Can that happen in relationships of care? I think it can. Parents who intend to be caring towards their children and do, I think, some really awful things to their kids, sometimes they can just demand that the kid forgive them and that's supposed to be the end of it. That should not be ever acceptable. And so that's one of the big lessons, is that the powerful cannot demand forgiveness for the evil that they've done. As a matter of fact, forgiveness has to come from the person who actually suffered the evil when and if they are ready. And it's their choice.

[46:03] **Martin Robb:** Yeah, I mean, I like that, the idea of forgiveness being voluntary, but also what you were saying before about that kind of reciprocal forgiveness and forgiveness of self being quite central to caring relationship. Well, we're almost out of time, Ruth, but I wonder if I could end by just asking you what you're working on at the moment and whether there are any more books, chapters or articles in the pipeline for you.

[46:25] **Ruth Groenhout:** Always new stuff for an academic. First of all, if we're almost to the end, I want to say ‘thank you’. This is. I mean, it's just a fascinating conversation. And I do think care ethics is important. So I think it's wonderful that you're actually getting people thinking about it in importance ways. Thank you. One of the books I'm working on is less care theory. Although it's connected in certain ways. I've been interested in how globally we should think about healthcare and particularly elderly care. As the elderly population is growing, they're very vulnerable in a lot of places, and how do we even approach that? So the thing I got, as a philosopher, I got interested in, was the question of, of if we're going to talk about what healthcare should be doing for the elderly, one of the things we have to do is actually define health, which is a pretty tricky thing to do because we have several different definitions sort of floating in the atmosphere. And so I'm comparing the view of health that is probably the most prominent, the one that comes from the World Health

Organization, and it's a very good definition, has had a lot of important things, but also has been criticized a lot because it's so central to many things. And then I compare and contrast that there's a naturalistic view of health. They call themselves naturalistic, that really buys into a sort of evolutionary picture that if we want to think about health, we need to think about reproduction and survival, as a matter of fact, of some of the important things. Right off the bat, you have to decide if you're thinking about species reproduction, survival, or individual reproduction to survival, because they're very different. But it is an interesting approach to health, and I think it underlies some of the things that people think about when they're thinking about health. For example, when the pandemics are coming up and people are thinking about who should get ventilators, if there are not enough ventilators for people suffering during the pandemic, one of the issues that comes up is can we take the ventilators away from nursing homes or assisted living homes and, as a matter of fact, give them to the middle aged folks who may have kids, have jobs, and the ventilator, for a short period of time will allow them to go back to that productive part of society. Quite honestly, I think that does buy very heavily into that sort of a 'how do we keep the species survival going' view of health much more than each individual should be getting exactly the same kind of care. And so what I do is look at some of these differences and how they would affect how we think about what healthcare ought to be offering with limited resources, a whole, you know, whole globe of people who are trying to, trying to stay alive and keep their societies and their cultures alive as their culture ages. So that one, I'm having kind of, it's a really interesting topic. And again, I will not have any good answers because, as a matter of fact, there aren't any simple answers. But I do think just getting clear about what some of the questions are is worth our time. So that one I've been working on. Also I've been working on a project with a group of folks connecting the Netherlands to the US on the question of over treatment in end of life care, which I think is a really crucial issue. And so I've written a chapter on care ethics and over treatment and how we might be thinking about some of those issues again, arguing that caring for a patient is not the same thing as aggressive treatment, always. It can actually sort of be undercut by aggressive treatment when you get into end of life care, and that one should be coming out in the next year or so, and I'm kind of excited about that one.

[50:11] **Martin Robb:** Great. I'm looking forward to reading it and maybe I'll ask you after the recording to send me the link to that so we can put that in the show notes to the episode. Well, it just remains for me to say thank you, Ruth, for today and providing such full and thoughtful answers to all my questions. It's been really nice having you as a guest on the podcast, and I wish you all the best in your future work in the field of healthcare ethics.

[50:35] **Ruth Groenhout:** Thank you. I appreciate that. And as I said, this has been a great conversation. I've really enjoyed it. So, and I hope other folks listening to it, yeah, get their thoughts moving as a result of the questions that you're asking. Thank you.

[50:48] **Martin Robb:** No, I've enjoyed it too. So that's all we have time for on this episode of *Careful Thinking*. If you've enjoyed this episode, I hope you'll subscribe wherever you get your podcasts and spread the word to other people who you think might be interested. If you'd like to comment or provide feedback on this or any other episode, or if you want to suggest a guest or a topic for a future episode, you can email me at carefulthinkingpodcast@gmail.com or you can leave a comment on my Substack, which you

can find at carefulthinking.substack.com. All of these details are on the podcast website together with the show notes for this episode. Thank you for listening and see you next time.