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RICE UNIVERSITY

CARING DIFFERENTLY: SEXUAL DIFFERENCE AND THE ETHICS OF HEALTH CARE RELATIONSHIPS

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE DOCTOR OF PHILOSOPHY

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ABSTRACT

Caring Differently: Sexual Difference and the Ethics of Health Care Relationships

by

Susan McPhail Wittjen

The ethical issues that are associated with interprofessional relationships in health care affect the care that patients receive in an institutional setting. There are many components of difference that affect relationships, but this work focuses on sexual difference and how it is revealed in the discourse of health care. Since the ethical obligations of health care providers historically have been derived from the roles of those professionals, the patient and provider relationship is described to establish the obligations of nurses, physical therapists, and physicians to patients. Because health care principles traditionally have been narrowly interpreted and applied, as well as limited in choosing ethical cases for analysis, the traditional ethical frameworks of principism and casuistry have been insufficient in addressing the ethical concerns that arise from interprofessional relationships. A feminine ethic of care is also inadequate in addressing these concerns because it is not sensitive to sexual difference and because it involves the possibility of promoting self-sacrifice. Luce Irigaray uses a technique of mimesis to expose and undermine sexual indifference in several western texts to explain how woman's voice has been overlooked in a culture based on masculine discourse. Her phenomenological interpretation of woman's body as being fluid, multiple, and intermediate is associated with those health care professions that are grounded in maternal nurturing and touching. These qualities are also revealed in the gendered discourse that permeates health care. Using Irigaray's work on feminine imaginary and gendered discourse, health care ethical issues can be analyzed at a deeper level than via principism, casuistry, or care. By recognizing how the gendered nature of health care discourse prevents the female voice from contributing to the decision-making process, new and creative possibilities for approaching ethical issues can be developed to provide the patient with care based on a broader interpretation of the issues. A case study based on a patient at the end-of-life is used to illustrate how the recognition of the role of sexual difference in ethical analysis can affect how decisions about patient care are made.
Acknowledgments

Many people have helped me in various ways during my nine years of study in the Department of Religious Studies at Rice, and it would be impossible to recognize all of them. A broad community of faculty, staff, graduate students, friends, and family have sustained me throughout these years. During this period of my life, I have also grown in my personal faith and recognize that only through God’s love and grace have I been able to accomplish this daunting task.

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My life changed drastically during the second year of graduate school when I married Gaddis P. Wittjen. He read and edited every paper that I wrote and discussed every aspect of each chapter of this dissertation through its many revisions. It is impossible to put into words how much his unconditional love and constant support have sustained me through these years. He knows. I dedicate this dissertation to him.
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Consequences of ethical analysis and sexual difference

Analysis of case using sexual difference

Relevance of sexual difference and gendered discourse for health care ethics

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Chapter 1

Introduction

Throughout my twenty-four years in health care as a clinical physical therapist I have been involved in and witnessed numerous situations with ethical ramifications. One of the most pervasive and persistent ethical questions that has been of concern to me is how the relationships among health care providers affect the quality of care that patients receive. Throughout this work I will be referring to the relationships among nurses, physical therapists, and physicians as examples of health care providers who regularly interact in the provision of health care to patients.

Although an empirical study of how health care providers behave towards each other might be possible by surveying the involved parties with a questionnaire, I believe there are inherent limits to such an approach, and therefore this study seeks to examine these relationships from a more philosophical perspective. An empirical analysis would involve limitations based on the types of discourses used in health care that have underlying philosophical issues, especially those related to gender. These limitations and problems would make it difficult for health care professionals to comment on their relationships with other caregivers. The use of masculine discourse, as I will describe later and will associate with the medical profession, limits physicians from being able to recognize the ethical issues involved in interprofessional relationships. Further, I have observed that nonphysician health care providers often will not openly discuss the ethical
concerns of interprofessional relationships and similarly would have difficulty answering questions about their relationships with physicians. Nonphysician health care providers would not be able to answer such questions because they are enmeshed in an institutional masculine discourse and have learned how to manipulate the system to obtain their desired outcomes in patient care, and therefore may not recognize that there are ethical considerations related to their relationships. Nonphysician health care providers have learned that their voices are not recognized as valuable and have accepted their inferior positions in the health care system, and thus may not participate in a study that they believe would be of little value in changing the system. This work addresses how gendered discourse relates to the ethical implications of the relationships among these groups of health care providers, and furthermore how that discourse affects patient care.

Although this work will only address the components of relationships that involve gender and authority, I acknowledge that there are several other components of difference that enter into relationships, especially those in health care. For example race¹, sexual orientation, and cultural differences are of particular concern in the professions of nursing, physical therapy, and medicine. By focusing on sexual difference, I do not intend to imply that these other components of difference are not of particular importance regarding the interprofessional relationships in health care. In fact, by recognizing that sexual difference has been overlooked in the analysis of ethical issues in health care, we can become attuned to how these other aspects of difference have also been overlooked.
Clinical examples of the ethical issues involved in health care relationships will be provided throughout this work. However, the final chapter will focus on one particular case that includes the ethical concerns that will have been addressed in the previous chapters. This case involves the end-of-life decisions that must be made about the care of a man dying with cancer who does not have an advance directive and whose family has asked that the decisions be made for them by the health care team. The case study involves how a physician’s authority and position in the hierarchical system of health care limits the number of voices participating in decision-making about patient care. The case also illustrates the potential harm to patients, nonphysicians, and physicians that can arise from within health care relationships when they are grounded solely in masculine discourse. I will argue that better outcomes would be attained if feminine discourse were recognized and valued in addition to the dominant masculine discourse, so that everyone with a stake in the care of a patient could have a voice in the decision-making process. If sexual difference became a basis for health care discourse, there would be a much greater possibility that an environment of cooperation and respect could be established, leading to better patient care, including respect for patients’ wishes. My goal is to explain how we can achieve this outcome by using Luce Irigaray’s work on sexual difference and applying it to the ethical ramifications of health care relationships.

Before discussing the importance of sexual difference and gendered discourse to patient care, I will begin by describing the two sets of relationships that are involved in the ethical problems. Although the patient/provider relationship is intertwined with the
relationships among health care providers, I will first discuss these two sets of relationships separately in order to adequately describe them and the ethical frameworks that have been traditionally used to analyze ethical concerns that arise from within the relationships. Since the patient is the focal point of health care, I will address the relationship of the provider with the patient in the next chapter. I will describe how each of these health care provider groups interacts with patients and how their roles in health care have been the basis of their duties toward patients. Since I will later discuss how Beauchamp and Childress define the principle of beneficence, using the role obligations of physicians, it is important to describe the various patient care roles of health care providers and how they historically developed. This will play an important role in the later analysis of the insufficiency of traditional ethics to address concerns of nonphysician health care providers.

In addition to a principle-based ethic, I will critique Nel Noddings’ presentation of a feminine ethic of care since it directly involves relationships between patients and health care providers. I will explain how her description of an ethic of care can be harmful to health care providers and will recommend specific limitations that would need to be included in her ethic to protect the "one-caring2". Further, I will offer a somewhat different distinction between caring-for3 as a minimal obligation and caring-about as an ideal. In the final chapter I will return to the ethical frameworks of principilism and care after presenting Irigaray’s work on sexual difference, and I will explain how gendered discourse plays an important role in these ethical models. After distinguishing feminine
discourse from masculine discourse, I will explain how masculine discourse has constrained principlism and care and has contributed to their being insufficient in addressing the specific concerns involving relationships.

After presenting the nature and importance of the patient/provider relationship and some of its related ethical concerns, I will then focus directly on the ethical considerations that develop from within relationships among nurses, physical therapists, and physicians in the third chapter. By describing how these professional groups developed historically, educationally, and culturally within the health care environment, I will be able to show how the traditional hierarchies in health care developed. I will describe how structural and dynamic elements are inherent aspects of relationships.

The relatively stable structural elements are those associated with authority, education, socio-economic levels, and gender. These will be discussed in order to illustrate how the relationships among health care providers developed historically within an environment in which physicians maintained a hierarchically superior position to other health care providers. While these structural elements give an appearance that health care occurs within a rigid system dominated by a singular voice, health care is an ever-changing environment involving different patients and their various responses to health care and involving constant advances in technology, thus dynamic elements are also a component of the health care system. I will address the specific dynamic elements that affect interprofessional relationships, including the multiplicity of levels and roles of
practitioners who provide patient care, the level of intimacy that may develop in the provision of care, and the public aspect of patient care, which intrinsically can be and often is of a very private nature. I will explain how these dynamic elements add a dimension of instability to the interprofessional relationships that have historically been established on a stable authoritative and hierarchical model.

Principlism and casuistry have been adequate in addressing many ethical issues in health care, but I will discuss why they are not sufficient in analyzing the ethical concerns that are inherent in health care relationships. After describing and comparing principlism and casuistry, I will discuss three reasons why they are limited in analyzing ethical concerns related to health care relationships. Those limitations are related to how the principles have been interpreted, applied, and used to choose cases for ethical analysis. A narrow interpretation of the principles, which is affected by the gender and authority of those invoking them, limits their ability to be used in the ethical analysis of relationships. Principlism and casuistry are also limited by the ways in which the principles have been applied and how ethical cases are chosen for consideration. These inadequacies will be further related to gendered discourse after the work of Irigaray is presented.

After delineating the nature of the health care relationships that are of concern in this work and explaining how the traditional ethical methodologies of principlism, casuistry, and care have been inadequate in addressing the ethical concerns that arise from these relationships, I will discuss the relevancy of Luce Irigaray’s work to health care ethical
analysis in chapter four. Although her work has not been applied in consideration of health care ethics previously, I will explain why her interpretation of sexual difference is appropriate in this environment in the final chapter.

In the fourth chapter I will temporarily leave the health care environment in order to discuss the significance of Irigaray’s work on sexual difference and gendered discourse. Since discourse is often not recognized as being gendered since it is commonly portrayed as being neutral, I will discuss Irigaray’s use of mimesis to reveal the significance of gendered discourse. In order to explain her use of mimesis and how she engages western writers who have promoted language as being indifferent to gender, I have chosen to discuss her explanation of Freud’s emphasis on sexual indifference and how that view has affected the development of women. I will also describe how Irigaray interprets Plato’s use of Diotima’s absent voice. Her mimetic work reveals the extent to which woman’s voice has been affected and silenced by influential western writers.

Irigaray’s phenomenological interpretation of woman’s body is influenced by the work of Merleau-Ponty and is one of the most unique aspects of her philosophy. She interprets the female body and woman’s experiences in the world, including the maternal function, as having qualities of fluidity, multiplicity, and intermediacy. She uses mimesis to reveal how woman has historically held the place of object and how woman’s voice has been silenced. In response to Lacan’s placing woman as a mirror image to man, Irigaray uses sexual difference to interpret woman as a subject with self-awareness. Since Irigaray’s
presentation of gendered discourse is important for my work in the analysis of health care relationships, I will discuss her depiction of the feminine imaginary and how it influences feminine discourse. Once woman can recognize a pre-discursive feminine imaginary, she must then learn to translate it into discourse. Irigaray uses the examples of mystic language and the sensible transcendental to discuss feminine discourse without trying to define it, which she claims would be impossible.

In the final chapter, I will return to health care relationships and apply Irigaray's work on sexual difference and gendered discourse to the ethical analysis of these relationships by using a case study as an example. I will address how patients, nonphysicians, and physicians potentially can be harmed by reliance on the traditional ethical analyses of principlism, casuistry, and care, which are grounded in masculine discourse. The case study will illustrate how the traditional ethical frameworks could be used to analyze a case without being sensitized to gendered discourse. I will then incorporate an analysis of the case using gendered discourse and discuss how the recognition of other voices in health care can change the appearance and outcome of a case.

Using Irigaray's interpretation of woman's body as having the qualities of multiplicity, fluidity, and intermediacy, I will describe how these qualities would be of benefit in an ethical analysis that incorporated feminine discourse into the process. By recognizing a different discourse, other voices could contribute to the decision-making process involving patients. Since I am not attempting to prioritize feminine discourse, I will
discuss how feminine and masculine discourse need to be balanced in the health care setting. I not only provide examples of policies that would promote both discourses, but also provide an example of how students could be taught to be sensitive to the importance of listening to different discourses. A wider array of possibilities exists in patient care if ethical analysis were grounded in sexual difference. By recognizing feminine and masculine discourse as valuable components of health care ethical analysis, patients would benefit from interprofessional relationships built on cooperation and respect that promote an openness to multiple voices.

NOTES

Chapter One

1. In "Racism in U.S. Nursing," in Medical Anthropology Quarterly, 7, no. 4, December 1993, 346-362, Evelyn L. Barbee describes how racism has been denied in nursing and describes the attributes of nursing that allowed that phenomenon to occur. She then describes three types of racism that are evident in nursing. While I am sensitive to other aspects of difference that could be factors in the manner in which health providers relate, I am focusing this work on sexual difference and how the discourses and ethics of health care are affected by gender.

2. The terms "one-caring" and "cared-for" are used by Noddings to describe the two persons involved in a caring relationship. She uses these terms to indicate who is providing and who is receiving the care.

3. I will be using the terms "caring-for" as a provision of the minimally obligated technical care for patients, and "caring-about" as including an emotional component that sets it apart as an ideal. These will be defined more fully later and compared to Noddings' use of the term "care".
Chapter 2

The Patient/Provider Relationship

Introduction

The ultimate goal of this work is to analyze how interprofessional relationships in health care affect the quality of care that patients receive in health care institutions. First, however, I will begin by examining the relationship that develops between patients and providers because this relationship is primary in health care. This chapter will include both a description of the patient/provider relationship and a delineation of the differences of this relationship from other business relationships in order to show that there are significant, specific, and unique ethical issues involved in this relationship. This chapter will discuss both physician and nonphysician health care providers' obligations to patients. I will explain how these obligations have arisen from the roles of these groups by describing how the roles of health care practitioners historically have evolved. Further, I will describe how the health care provider's obligation of trust is derived from the patient's vulnerability. Finally, this chapter will address the role of care in the patient/provider relationship. Although Luce Irigaray's work will not be fully described until the fourth chapter, I will indicate instances throughout this chapter where Irigaray's perspective will later become pertinent in this work.
Description of Patient/Provider Relationship

Nature and Importance of the Relationship

A person becomes a patient in the health care system when that person needs the assistance of a health care provider in order to return to a healthy state. An important ethical relationship develops between the patient and the health care provider since the well-being of the patient is at stake. What a health care provider says and does may impact the life and well-being of the patient. Because health care professionals’ purpose is to care for others’ lives, they have special obligations that are derived from their roles in health care. These obligations provide some of the distinguishing components of the patient/provider relationship that makes it different from a more common business relationship unrelated to health care. These obligations will be discussed later in this chapter. I will describe this important relationship’s unique characteristics and discuss how the relationships among health care providers can affect the patient’s well-being.

The patient/provider relationship involves ethical issues because patients enter this relationship in a state of illness that places them in an abnormal and vulnerable state of being. The effects of illness on the patient set this relationship apart from other business relationships. When a person becomes ill and takes on the role of the patient, there are emotional, psychological, and physical effects that help establish a special relationship between the patient and the health care provider. Patients are in a vulnerable position because of the mental and physical changes they often undergo as a result of illness. They must trust that the health care provider will act in their best interest even when
their mental capacities may be diminished. This relationship also involves an imbalance in power between the patient and provider. In order to provide treatment a health care provider must have certain personal information regarding the patient as well as access to the patient’s body. In almost no public situation other than in health care would persons reveal intimate details of their private lives to a stranger or allow a stranger to touch them. Health care providers have significant power when they are granted this access to the otherwise private aspects of another person’s life. There is a further power imbalance since health care providers are not expected to provide reciprocal information to the patients; thus the relationship is one-sided. This differs from other business situations, where personal and intimate information is usually not needed for a transaction. The manner in which a health care professional manages patient information has ethical ramifications since it involves respect for the patient and beneficence towards them. How these specific obligations are derived from the roles of health care providers will be further investigated in this chapter.

An imbalance of power also exists between patients and health care providers because of the differences in their levels of knowledge. Patients generally have less knowledge and information about disease processes, and must trust that their caregivers have the necessary knowledge and skills to provide competent care-for them. Patients rely on the expertise of health care providers and expect that these caregivers will provide appropriate care. Health care providers are considered professionals who have engaged in extensive training concerning the function of the human body and have acquired a
unique understanding about health and illness. The training of physicians, nurses, and physical therapists involves activities to learn about the human body that most persons outside of health care would not encounter, such as dissecting a human body or learning to perform physical examinations. Health care providers learn that these activities involve the principles of respect for patients as well as other significant health care principles. I will describe how these principles are derived from the roles of health care providers. While patients may trust in their health care providers’ competence and beneficence, patients may be unaware of the internal conflicts that providers face and that may affect their care. In the next chapter I will address some of the interprofessional conflicts that affect the care of the patient.

Since patients often do not have the knowledge or skills required to diagnose their own problems or to restore their health, they must seek advice and care from a person who is thought to be knowledgeable in the care of the human body. Patients must trust that health care providers are competent and acting in their best interest. If a patient perceives that the provider is not acting on behalf of that person’s welfare, the patient may decide not to follow the provider’s advice, resulting in possibly negative results for the patient. Further, illness affects many aspects of that person’s life, especially if the person is limited in participating in normal personal and professional activities. As a person moves from a healthy to an unhealthy state, that person becomes vulnerable to outside influences and is at a disadvantage physically, emotionally, and psychologically. This vulnerability of the patient heightens the need for trustworthiness on the part of the
health care provider.

Another unique aspect of the patient/provider relationship that makes it different from other business relationships is its place on a continuum between stranger and intimate. Often patients and providers are strangers at first, but as patients reveal personal information and allow access to their bodies, the relationship quickly changes to one that appears more intimate even though it does not deepen to the level of family or other intimate relationships. Moreover the relationship may deepen and move in a more intimate direction because the health care professional may become emotionally involved in the patient’s care. Therefore, the patient/provider relationship can be placed on a continuum between stranger and intimate, and may fluctuate between the two. This fluctuation occurs because health care is situated within an institutional setting in which a deeply intimate relationship is not appropriate. Yet health care is provided to help a person return to a healthy state and often involves interactions which would normally be considered intimate. Due to managed care, it is becoming more common that patients and providers enter into relationships as strangers since patients are often unable to choose their providers and they are reassigned more frequently. The system works because patients tend to trust that health care providers are working in their best interest. The trust that patients place in their caregivers is important because they usually do not have the knowledge or expertise to handle their own health problems. The patient/provider relationship is therefore unique and involves powerful forces which have the potential for affecting the patient’s well-being. As I will discuss in the final chapter,
the patient/provider relationship involves elements that are dynamic and fluid, which will be described using Irigaray’s work on feminine discourse.

Physician/Patient Relationship as Focus

Traditionally, the relationship between patient and health care provider focuses on the physician as provider. The patient/physician relationship has been described as a therapeutic relationship because the relationship itself may influence how well the patient responds to a medical interaction. The placebo effect, which results in an effect on a patient without anything specifically being done to treat the person, has been described as being common in health care. Howard Brody explains that the physician’s influence over the patient’s response to treatment is pervasive in health care (1992, 34, 132-133). For example, if there is a good patient/physician relationship, the patient may have more confidence in the physician and follow a recommended treatment protocol. Therefore, the relationship between patients and physicians can affect the patients’ response to illness and their overall well-being.

The ethical relationship between physician and patient has been used as the paradigm for other provider/patient relationships. Beauchamp and Childress have described how the roles of physicians have been used to derive their obligations to patients with little attention to the roles of nonphysician caregivers (1994, 37). Although there are numerous other health care providers in practice today, the physician’s relationship with the patient historically has received the most attention. There are several possible
reasons that this group has been the focus of ethical analysis. Some of the reasons that physicians have been studied more than others include the historical development of the professions, the way that the institution of health care functions with physicians as gatekeepers, and issues related to gender. I will delve more deeply into these issues in the next chapter when I discuss the nature of the relationships between health care providers. However, it is important to recognize that although the patient/provider relationship has usually been described from the perspective of the physician as provider, nonphysician caregivers also develop very important relationships with patients that also affect the patients’ well-being. As I will discuss, nonphysician caregivers provide the majority of hands-on care for patients and have many opportunities to develop significant relationships with them.

Nature of Nonphysician/Patient Relationship

Patients within an institutional health care setting interact with a variety of health care providers other than physicians. While recognizing that there are numerous other nonphysician caregivers who also develop relationships with patients, I have chosen to look specifically at nurses and physical therapists. This will not be an empirical study of these professions; rather, I base my observations on twenty-four years of experience as a physical therapist who has been practicing in a variety of health care settings. Although there is a wide variety of ethical issues in health care, nurses and physical therapists form relationships with patients that involve many of the same ethical issues as physicians. Before I address the issues relating to the ethical obligations of health care
providers, I will first describe how these two groups interact with patients and the nature of the relationship that is formed.

Although many nurses and physical therapists practice within institutional settings, they often care for patients in situations where physicians are not present. Since most physicians in private practice have offices away from the hospital, most hands-on patient care by nurses and physical therapists takes place when physicians are not present. These health care providers are responsible for patients who may be critically ill and require ongoing monitoring of their conditions. These nonphysician providers must independently judge the status of patients and respond to their needs. Generally, physicians make rounds and briefly interact with their patients and then leave the hospital to see patients in their offices. This practice is somewhat modified in teaching hospitals where medical students, interns, and residents are often more available. However, in those situations, the attending physicians are often more involved in other activities than in nonteaching hospitals and are less available for direct patient interaction. Further, many patients receive care in hospitals that are nonteaching facilities. While there may be exceptions to this, it has been my experience that residents do not have more time to interact directly with patients than do the attending physicians, and that patients do not want to form relationships with physicians in training who are not considered their primary physician. Some patients may be unaware that residents are still in training, but others recognize that residents are still "under supervision" and want the relationship with the attending physician. In general then, nurses and physical therapists perform their
caregiving responsibilities independently in settings where their judgment is critical for the patients’ well-being.

Nurses and physical therapists spend more time individually with patients than do physicians in the daily provision of care and rehabilitation. They are usually the ones who recognize changes in the patient’s status and who must respond to the fluctuating status of the patient and notify the physician if necessary. Patients would not be hospitalized if they did not need ongoing care and monitoring by skilled professionals; otherwise they could be treated at home. With the ongoing advances in health care technology, nurses and physical therapists are responsible for complex treatment regimens and must maintain a substantial knowledge base to be able to care competently for patients in an ever-changing environment. Nurses must know normal and abnormal responses to new treatments and how to adjust their care for patients. Physical therapists must know how to provide care to patients who are receiving technologically advanced treatments and be able to assess a patient’s tolerance for rehabilitation. Further, due to cost-containment measures, nurses and physical therapists, like physicians, are also expected to provide care efficiently to patients who will be discharged sooner than previously allowed.

Since nurses and physical therapists spend significant amounts of time with patients in providing hands-on care, patients and their families often ask these caregivers questions about their illness and their care. Such interactions provide a means for significant
relationships to develop. Patients and families ask specific questions about their prognosis and the purposes of treatments, and they want opinions about what choices they should make. Patients who are very ill often confide in caregivers who have been working closely with them about their desires for the future. Patients may say that they believe that they are prepared for death and how much they dislike the lack of independence brought on by their illness. They often complain about the discomfort of life-sustaining treatments. Patients confide to their caregivers about their families regarding the care that they have received when they are home. For example, some patients may complain about the lack of attention that is paid to them by their families. These types of conversations reveal that patients and nonphysician caregivers often form trusting relationships.

Patients and families often willingly enter into relationships with nonphysician caregivers. The professions of nursing and physical therapy have grown to accept the responsibility for decisions made regarding patients. This is emphasized by both groups’ professional organizations, laws, and malpractice insurers. These professional groups are guided by codes of ethics that state that nurses and physical therapists assume ethical responsibility for their judgments with patients. Further, most of these practitioners carry malpractice insurance because the law has been interpreted so that legally they are held responsible for their decisions and actions without regard to what they were instructed to do by a physician. Nurses and physical therapists enter into relationships with patients understanding that they are legally and ethically responsible for their actions. This is an
important aspect of the ethical obligations assumed by nonphysician caregivers.

**Evolution of Professions**

Since the health care field has changed so dramatically over the last three decades, it is necessary to discuss how the professions themselves have changed since ethical obligations have traditionally been derived from the role-specific duties of health care providers. It is particularly relevant that the nursing and physical therapy professions have evolved to include more responsibilities and a greater scope of duties. This expansion has greatly affected provider/patient relationships as well as interprofessional relationships, which will be discussed in the next chapter. While nursing, physical therapy, and medicine have developed in response to technological advances as well as economic forces, they continue to be distinct professions that emphasize different aspects of patient care. I will argue that the professions of nursing and physical therapy have evolved from being extensions of the physician to being caregivers who must use their independent judgment and knowledge to care for patients. While medicine has also changed due to technology, and more recently due to economic forces, I will describe how the professions of nursing and physical therapy have undergone more substantial internal changes.

The history of nursing has roots in the family where taking care of ill family members was the woman’s traditional duty. In the early days of nursing, caring for family members was thought to be "central to a woman’s self-sacrificing service to others"\(^5\)
(Reverby 1987, 11). Even when a physician was available, it was the nurse who provided the ongoing care for the patients. As hospitals developed, nurses' responsibilities continued to include the hands-on care of both chronically and acutely ill patients. The association of nursing with the woman’s role in the home helped maintain its separate status from medicine. Although nurses provided care to patients under the authority of physicians and were expected to treat physicians with deference, they were placed within a female hierarchy that was separate from the physicians’ organizational structure (42-43). When nurses began to engage in formal training in the 1870’s, there was an emphasis on the character of the person, strict discipline, and a loyalty to the physician’s authority. This focus on the nurse’s behavior, rather than on knowledge and skills, maintained a distinction that nurses were considered of secondary importance in the health care environment.

Although nursing ethics texts from the early 1900’s state that nurses should not "obey physicians making obvious mistakes," nurses were taught to follow physicians’ "orders" and to be loyal to the physician (Jameton 1984, 36-38). Early in their history nurses were not encouraged to make independent judgments, although there were exceptional cases in which nurses defied the authority of the physician to save a patient’s lives. This is evidence of the historical ambiguity that is a part of a nurse’s professional life. The ability of nurses to handle ambiguous situations and relationships will be related to Irigaray’s work on sexual difference in the final chapter.
With the rise of technology in the 1960's, nurses were placed in positions to oversee many of the new technological developments with patients. Their educational standards escalated to keep up with the growing demands. Nurses now provide care to critically ill patients who in the past would never have been able to survive. The hospital setting continues to be where physicians "make rounds" on patients and then leave the ongoing care to the nurses who are expected to be able to recognize when a patient's condition changes and to respond appropriately. Further, cost-containment has placed a greater burden on nurses to help patients recover from illness more quickly and to prepare patients for earlier discharge. Nurses must care for patients more efficiently while recognizing that many are in fragile medical conditions.

As patients learn more about health care from the popular press, nurses must also be able to communicate to patients on a level that increases the understanding of their illnesses as well as the rationale for their care. Nurses are often the intermediary between patient and physician and provide information to both parties. With the advent of managed care, nurses have taken on greater responsibilities, and often perform the duties of gatekeeper, that is, often determining whether the patient will see the physician. Nurses have many different duties in patient care which include providing ongoing care to patients and monitoring changes in patients' status. These multiple duties place them in a position critical to the well-being of patients.

The history of the profession of physical therapy is shorter than nursing's since it began
during World War I when reconstruction aides provided care and rehabilitation to wounded soldiers. Physical therapy continued its growth during the polio epidemic of the 1950's when those patients needed extensive rehabilitation. Physical therapists worked closely with physicians by providing the necessary hands-on rehabilitative care that was often quite time-consuming. In the early years of the profession the majority of physical therapists worked in hospitals where they provided care as "ordered" by physicians. As less invasive surgical procedures were developed, such as arthroscopy, patients stayed in the hospital for shorter periods and needed less inpatient care. Therefore, more physical therapists have moved into independently owned outpatient clinics. Now the majority of physical therapists work outside of the hospital setting, but those who remain in the hospital, like nurses, have adapted to caring for more critically ill patients. They have been expected to mobilize patients earlier to reduce hospital stays and provide rehabilitation for patients whose conditions are often unstable.

In many states physical therapists can now treat patients who have not been referred by a physician. Even in situations where patients are sent by physicians for care, there is usually no diagnosis, only a description of the symptom, such as low back pain, and an open referral to treat the patient as necessary. Physical therapists must first evaluate the patient to determine a diagnosis and then treat the patient accordingly. Especially within managed care systems, more patients are being referred from family practitioners who have not been trained in movement dysfunctions, and who rely heavily on the expertise of the physical therapists. Physical therapists
provide care to patients who trust that the therapist has the knowledge and desire to help them achieve a higher level of function. Although a hospitalized patient’s diagnosis is known, there is usually little input from the physician on how to accomplish the goals of rehabilitation. Therefore, the physical therapist’s initial evaluation of the patient is critical in setting goals for a patient’s rehabilitation. Physical therapists must use their clinical judgment in deciding how to move the patient through a physical therapy treatment program.

Because physical therapists spend significant amounts of time with patients trying to reduce their pain or increase their functional level, a relationship develops as the patient recognizes that the therapist is interested in the patient’s well-being. Often families also become involved with the therapist as they are taught how to work with the patient after discharge from the hospital. As with nurses, patients often tell physical therapists their desires regarding the end of life or how they view their current situation. Sometimes they reveal information about their family situation, such as a child who has taken advantage of them financially. This is evidence that patients are willing to develop relationships with physical therapists and that this relationship can affect the care that the patient receives.

Each of the professions of nursing, physical therapy, and medicine is distinct in its education and has specific roles in their provision of health care. However, for the purposes of the discussion on the patient/provider relationship it is necessary to discuss
the similarities in the roles of physicians and nonphysicians to patients to establish the important role of the nonphysician in health care. Because of the tremendous evolution in health care, especially in technological advances, increases in educational opportunities, and the managed care environment, all health care practitioners have obligations to patients that were once only associated with physicians. Nurses and physical therapists now recognize their ethical obligations to patients since their roles include practicing independently outside the presence of physicians and demonstrating judgment in the care of patients. Since these professions have evolved to a more complex level of patient care, they have also assumed a much greater responsibility for patient care. In the next chapter I will explain how Beauchamp and Childress’ use of the physician’s role as the basis of the principle of beneficence has affected how health care providers relate to each other. I will use Irigaray’s work on sexual difference as a way to recognize and celebrate the multiplicity of the roles of nurses and physical therapists in health care and help to make the interprofessional relationships of health care providers less hierarchical.

Role-Specific Duties and Obligations

Before discussing how obligations are derived from the roles of health care providers, I will distinguish between general obligations and specific obligations. General obligations are those commitments that we have toward all other human beings based on their humanity and inherent worth as such. These obligations to others are generalizable to all who are similarly situated and relate to the interests of society at large and its
preservation. The principle of beneficence is an example of a positive general obligation, that is, we should work to benefit others. Working to help others is a way to recognize that others have helped us and to further the common goals of society. While there is "an obligation to help others further their important and legitimate interests," there are limits to what we are obligated to provide others (Beauchamp and Childress 1994, 260). Extreme self-sacrifice is an example. General obligations are those directed to all with whom we engage in social arrangements and account for our duties toward others.

General obligations also exist in health care as they do throughout society. There are obligations between providers and patients as well as among health care providers. The principles of beneficence, nonmaleficence, respect for the autonomy of persons, and justice all include obligations that every person has toward others and will be discussed more thoroughly in chapter three when principlism is presented. Although each of these principles includes general obligations that are incumbent upon all persons, they can also be interpreted more narrowly to describe specific obligations that are directed toward certain individuals.

Specific obligations are those that exist between specific persons. Health care providers have specific obligations toward patients based on the nature of the patient/provider relationship that has been described above. Because patients are in a vulnerable position in health care based on their lack of power and knowledge, they must trust that the providers are working to further their well-being. Health care providers must consider
the consequences when they recommend certain procedures or perform treatments to patients because there may be positive or negative results. Therefore, since health care providers are in a unique position in society, they have specific obligations based on their roles in the health care system. The patient/provider relationship involves special moral issues which are specific solely to health care. I will discuss how these obligations have been traditionally derived from the role-specific duties of physicians and how nonphysician health care providers and patients have been affected by this historically narrow view of specific obligations in health care.

Role-Specific Duties of Physicians

When Beauchamp and Childress describe how obligations are derived from the specific roles of health care providers, they use medicine as the prototype. Since physicians are the traditional gatekeepers to health care and patients often turn to them first for care, physicians’ duties to patients then would be a natural place to start. In describing the principle of beneficence, Beauchamp and Childress base it in "common morality and medical tradition" which include "long-standing, professional role obligations in medicine to provide medical benefits to patients" (1994, 37, underlining mine). They clearly associate the provision of benefit to patients with the medical profession. While this description of beneficence is not incorrect in depicting the primary role of physicians as providing the appropriate care to patients for their health care needs, my concern is that this use of medicine as the prototype of beneficence overlooks the obligations of beneficence that other health care providers have with patients. Beauchamp and
Childress provide the example of the physician's obligation to provide due care for patients and use the Principles of Medical Ethics of the American Medical Association as an example that this is a generally accepted obligation (1994, 195-196). Further, the traditional role of physicians not to harm patients provides a basis for the derivation of the principle of nonmaleficence. Beauchamp and Childress use end-of-life issues as examples of how the principle of nonmaleficence can be applied. For example, the principle of nonmaleficence may be invoked when trying to decide whether a life-sustaining modality would inflict more harm than good. They do not address the roles of nonphysician providers in patients' end-of-life decision-making, which I will argue in a later chapter are significant. I will explain shortly how the emphasis on the physician's role obligations has affected the relationship between patients and nonphysician caregivers.

**Nonphysician Health Care Providers' Obligations**

As I have discussed above, nonphysician health care providers also establish moral relationships with patients and therefore, owe specific obligations to patients. Like physicians, nurses and physical therapists usually enter the health care field because they are interested in helping others. This statement is based on years of interaction with nurses and participating in interviews with hundreds of prospective students seeking admission to physical therapy school. Further, the professions of nursing and physical therapy are not glamorous, powerful, or lucrative, so the motivation to enter one of these fields usually is the desire to help others.
The roles of the physician, nurse, and physical therapist are distinct, yet they have some similarities. Usually physicians are responsible for coordinating the overall health care of the patient. Their roles involve many aspects, but typically include advising patients on treatment options and referring patients to other health care providers as necessary. Usually when patients form relationships with nurses and physical therapists, especially in a hospital setting, there is already a physician/patient relationship in place. Patients often enter relationships with nurses and physical therapists as strangers and reveal to these health care providers both their personal information and their bodies in a similar manner as they do with physicians. Therefore, the relationships that nurses and physical therapists form with patients include the same issues of vulnerability and trust that the physician/patient relationship does. Nurses are responsible for carrying out physicians’ requested treatments for patients and for reporting the responses of the patients. Their primary role is to provide the necessary hands-on care to patients, and patients trust that they will provide the appropriate care. Hospitalized patients depend on the competence of the nurses who administer medication or other critical treatments.

Patients may not be aware that nurses reside in a dual hierarchical system that often places them in a difficult position. Nurses not only respond to the orders of the physicians, but they are also responsible as employees to the administration of the hospital. Nurses carry out the orders of various physicians and may have a different physician for each patient whose treatment regimen may differ slightly or significantly for similar diagnoses. Nurses must be capable of recognizing these differences and
responding appropriately. Further, nurses, as employees of the hospital, must follow the policies and procedures set forth by the hospital administration. At times nurses may have to decide between conflicting physician orders and institutional policies. Further, institutional goals may emphasize business decisions based on financial considerations that may place an employee in a position of internal conflict. For example, the facility may want patients to be discharged earlier than nurses or other health care providers would deem appropriate. However, even if nurses are uncomfortable with the expectations of the business-oriented administration, they must consider their obligations of loyalty to their employers. When faced with the objectives of an early discharge by a managed care organization, health care providers often find their obligations of beneficence toward patients in conflict with their obligations of loyalty to the hospital.

The role of the physical therapist also is to provide benefit for patients, especially in relation to returning patients to their highest possible functional level. Physical therapists work to increase patients' mobility, decrease their pain, or help them learn to live with a disability. The role-specific obligations that are derived from the duties of nurses and physical therapists are similar to physicians' obligations because the primary goal and motivation of all of these health care providers is to help patients. Like nurses, institutional physical therapists usually are situated in dual hierarchies. In a professional hierarchy, they receive referrals from physicians, and as employees, they are members of the hospital hierarchy. This may be less of a burden to physical therapists than to nurses since the majority of physical therapists work outside of hospitals and have many
other employment opportunities available. If physical therapists experience dissonance in their sense of obligations, they often have the opportunity to leave an institutional setting. This mobility contributes to a high turnover rate of physical therapists in hospital settings and allows conflicts to continue unaddressed.

Like nurses and physicians who do not specialize, many physical therapists treat patients with a variety of disorders, and patients trust that they are competent in all of these areas. Usually physical therapists treat patients without specific direction from a physician and determine the course of treatment that the patient will receive. The physical therapist usually receives a referral for rehabilitation and is expected to accomplish that task according to the therapist's judgment to choose and implement treatment modalities. Therefore, patients' recovery often depends on the expertise of physical therapists who provide care to patients using their independent judgment.

Nurses and physical therapists, therefore, have the specific moral obligations of beneficence and nonmaleficence to patients as physicians. Their roles of providing critical treatments to patients also give rise to obligations to respect the patient's autonomy and to treat patients with fairness. While the professions differ in how they perform their roles of helping patients, medicine, nursing, and physical therapy share similar specific obligations derived from their unique patient/provider relationships. Using Irigaray's philosophy of sexual difference and its impact on gendered discourse, I will explain in the final chapter how the roles and obligations of health care providers
have been described and valued differently due to a masculine discourse of health care.

The Role of an Ethic of Care

In addition to describing the obligations of health care providers being derived from their roles and duties, I will address the role of emotion and how caring-about patients influences ethical decision-making. Emotions arise within most human relationships, and in health care relationships the emotional component of the relationship may be expressed in the act of caring-about a patient\(^7\). Both patients and providers may experience emotional reactions while involved in the relationship. Patients experience a wide variety of emotions during their illness, such as anger, confusion, joy, or gratitude. They often express these emotions toward health care providers, especially nonphysician caregivers who are in close contact with them during a hospitalization. Health care providers who witness tragedy and experience difficult situations also have a wide range of emotions. In cases where the health care provider recognizes that there are limitations to what can be offered to help the patient physically or that the options of care are limited, the situation may become more emotional. Since these emotional responses may affect patient care, I will argue that the emotional response of the health care provider has ethical significance.

Caring-about a patient is the specific emotional response that I will address with regard to its ethical significance. First I will describe the difference between caring-for and caring-about patients. Then I will discuss how an ethic of care, understood as an ideal,
can be an important component of the patient/provider relationship\textsuperscript{8}. Although I will return to how gender becomes important in interprofessional relationships in the next chapter, I will now introduce how gender and an ethic of care have been juxtaposed and how that connection has affected this ethic. Although specific aspects of Nel Noddings' work on an ethic of care can be appropriately applied to the health care environment, certain parts of her work will also be critiqued, especially her use of the mother/child model. Because there is a danger that Noddings' ethic of care could be self-sacrificial, I will describe some necessary limitations on her presentation of an ethic of care which are necessary to make this ethic appropriate, especially for women. Irigaray's work on sexual difference and the self/other relationship will be used as a corrective to Noddings' work.

**Caring-For and Caring-About**

It is necessary to distinguish between caring-for a patient and caring-about a patient because each of these involves a different ethical issue. According to Nancy Jeczer, caring-for someone refers to the "exercise of a skill, with or without a particular attitude or feeling toward the object," and caring-about is "an attitude, feeling, or state of mind directed toward a person or circumstance" (1994, 62). Caring-about a patient involves an emotional response and a subjective component while caring-for usually means providing some level of action on behalf of a patient\textsuperscript{9}. Separating these two elements of caring in health care is important because they involve different ethical issues, that is, what is required of a health care provider and that which is considered ideal behavior.
In the health care environment patients must be cared-for as a minimum level of provision of services. Caring-for patients is the basic work of health care providers and is the reason that patients are admitted to hospitals. It is the basic service offered by the health care institution, and is the reason for its existence. Health care providers have an obligation to provide competent care-for patients as an aspect of beneficence. This is a basic and general obligation of all health care providers. Caring-about, in contrast, occurs after the provision of care has been established and the patient has entered into a relationship with the caregiver. After the minimal level of caring-for is established, there is an opportunity for a subjective component to develop. Since a health care provider is not obligated to have an emotional response to a patient, an emotional connection to a patient is more appropriately considered an aspect of an ideal of patient care.

In order to claim that caring-about patients is a moral ideal, it is necessary to address what is meant by an ideal. According to Beauchamp and Childress, moral ideals can either be held to ordinary or extraordinary standards. The ordinary standard of an ideal is considered a "moral minimum" and applies to all persons (1994, 483). Caring-for patients is an ordinary ideal since it is the minimum of what a health care provider is obligated to perform. Caring-about may be closer to what Beauchamp and Childress consider an extraordinary ideal, which is a "morality of aspiration in which individuals adopt moral ideals that do not hold for everyone" (1994, 483). In their discussion of extraordinary ideals, Beauchamp and Childress describe a continuum of experiences
rather than trying to divide actions between two extremes. Since caring-about certain
types of patients may be more or less difficult than caring-about others, and since each
provider has different abilities to provide a caring emotional support, what might be
extraordinary for one person may be ordinary caring-about for another person. Because
experiences with patients in the health care system are so complex and variable, it is
difficult to determine if an ideal has been achieved. As with beneficence, caring-about
is other-regarding and cannot be fully circumscribed or quantified because its
requirements are variable and indefinite. Both require a moral sense of judgment to
know when and how to offer them. I argue that patients would be better served when
caring-about is a component of overall care because health care providers would be more
sensitive to the needs of patients. Caring-about is an ideal that can be worked towards,
but it may remain uncertain whether the ideal has been met.

Caring-for and caring-about are related at the clinical level. Most patients are admitted
to a hospital as strangers to the caregivers, with the exception of physicians who may
already have developed an outpatient relationship with the patient. Whether there is an
established relationship previous to admission does not affect the obligation of caring-for
a patient. There is an obligation to care-for all patients competently. After the initiation
of care-for a patient, in some cases an emotional response of caring-about may develop
within the relationship. Therefore, unless competent caring-for first occurs, there is little
basis upon which to establish a subjective caring-about.
This is a different experience than in other business relationships in which an emotional component usually does not become part of the situation. The difference is due to the nature of health care. It involves the patient physically, mentally, and emotionally, so that a person’s whole being becomes a part of the relationship, not just the physical disability, or a financial concern as in a business arrangement. Further, health care often entails issues of life and death as well as intimate aspects of a person’s life and body. When a person becomes a patient, that person’s role in society is changed; a patient becomes dependent upon others for care, which may include a need for emotional as well as physical care. Health care providers must acknowledge this basic change that patients undergo, and recognize that emotional bonds can develop.

A health care provider who competently fulfills the necessary role obligations does not have to take the next step into caring-about the patient. A person cannot be forced to have an emotional response to patients, but caring-about patients often enriches the relationships between patient and provider. When we care-about someone else, we establish a connection which involves both an emotional component and an aspect of judgment (Fisher and Tronto 1990, 42). When a caregiver relates to a patient on an emotional level, the patient may be recognized more fully as an individual needing care. When the individual’s needs are considered, the provider may recognize the need for judgment in providing care rather than treating the person like all other patients with the same diagnosis. When health care providers connect to patients beyond the minimal obligations of meeting their physical needs, caregivers become more emotionally attuned
to their patients’ needs and wishes. According to Alisa Carse, the provider may be better aware of moral dilemmas in the care of the patient when caring-about occurs (1991, 14). When health care providers become more emotionally connected to a patient, they may be more open to listening to a patient’s fears, concerns, or desires. This may lead to caregivers responding to the patient more as an individual. When end-of-life decisions are being made, it is important to know as much about the patient’s wishes as possible so that decisions are appropriate. If a relationship involves caring-about, the patient may communicate more freely with the health care provider. This occurs because caring-about adds depth and a new dimension of closeness to the relationship that places the health care provider in a unique position to recognize and help communicate the ethical concerns of the patient. The relationship probably involves better communication, and more importantly, caring-about involves a greater awareness of the patient’s needs.

The ethical significance of caring-about is witnessed in the response to the patient, which is different from a minimal caring-for. It occurs in the context of the patient’s pain, fears, and concerns, that is, within the ongoing and changing state that the patient inhabits. As Manning’s biosocial view suggests, when a caregiver responds to the emotional needs of a patient, it is within a general societal "network" in which we share needs and responsibilities among all of our relationships (1992, xiv). The patient’s physical, psychological, social, and emotional needs are more fully considered when caring-about occurs. There is a difference in health care in caring-for a patient’s
needs which is obligatory and in relating to that person at an ideal emotional level of caring-about. Caring-about someone often involves a process that is dynamic and develops over time as it involves not only attending to the physical needs of the patient, but also those basic emotional needs as well. It is the ideal relationship between patient and provider because health care providers caring-about patients respond to the whole person on multiple levels. To offer care to others is to respond to them as individuals who have certain elements common to all persons. In order for caring-about to occur, the individual must be addressed within that person’s concrete reality.

Limitations to Caring-About

An ideal of caring-about patients should include certain limitations. Health care providers care-for numerous patients at one time. If they became emotionally involved with every patient, providers may become depleted emotionally, leading to a reduction in their abilities to provide the minimal caring-for that is required. Further, if caregivers become too involved in caring-about their patients, it may interfere with obligations of beneficence to other patients. They may spend too much time with one patient and family members to the detriment of other patients. Many health care providers face ongoing decisions of trying to determine how much emotional involvement is necessary with each patient. They need to be able to recognize whether their caring-about one patient means that other patients are negatively affected. To be an ethical action, caring-about a patient should not be harmful to the provider or to other persons.
If health care providers recognize that the emotional demands of caring-about patients are becoming harmful, they should have the freedom to withdraw from the situation if possible. Health care providers must be careful not to abandon patients; therefore any withdrawal needs to be accompanied by a transfer of care to another person. There is no obligation of self-sacrifice, so caregivers should protect themselves from depletion by others. This is often difficult in health care situations where staffing problems exist, especially within managed care environments. Health care providers might also have a difficult time withdrawing from caring-about a patient because they may be criticized by fellow providers who do not recognize that there are limitations to an emotional relationship with patients. I will return to this problem when I discuss Nel Noddings' work on care. Being able to protect oneself by placing limitations on caring-about is also related to Irigaray's work on the self/other relationship and will be discussed in a later chapter.

An Ethic of Care and the Involvement of Gender

Caring-for and caring-about are related to gender. I have already described how the nursing profession arose out of what society perceived to be the woman's duty to care for her family. Further, when Carol Gilligan first described an ethic of care and responsibility, she based it on studies involving young women who demonstrated these characteristics. Her work in developmental psychology opened up a new source of dialogue on gender and moral reasoning. Because Gilligan's work provided the groundwork for an ethic of care, it continues to be cited as basic to discussions involving
relationships. In response to Lawrence Kohlberg’s theory of moral development anchored "in principles of justice that are universal in application," Gilligan identified two moral voices that arise from either a justice orientation or a care orientation (1986, 311)\textsuperscript{12}. She described an ethic of care as one of "connection, theorized as primary and seen as fundamental in human life" as it focuses on relationships, experiences, and situations (1995, 122). This view changes the pattern of moral development as described by Kohlberg from a linear and hierarchical one to a pattern more like a network or a web.

Even though Gilligan surmised that her female subjects were more inclined to hear the moral voice of care and responsibility, she states that both genders are able to recognize both a care and a justice perspective in analyzing moral conflict. Gilligan did not specifically determine that the moral voices of care and justice were definitively split between the genders, but that the "pattern of predominance, although not gender specific, appeared to be gender related" (1986, 242). Her statement has led to intense debate about the relationship of gender to moral reasoning\textsuperscript{13}. Gilligan found through listening to women’s narratives that a woman’s experiences allow her to appreciate the significance of relationships and interactions with others in moral reasoning. Both Gilligan and Kohlberg refer to the importance of a person’s experiences in forming a moral voice, but Gilligan opened our ears so that other moral voices could be heard. She was a leader in trying to overcome the gender barriers that had been established by those like Kohlberg, who had used only male subjects in his studies. Yet by associating care
with the female gender, Gilligan may have also established a barrier to the acceptance of care as an ethical basis for reasoning. Gilligan’s work is noted as an early step in recognizing gender as an issue in moral reasoning and is used by Noddings as she develops her feminine ethic of care. I will describe the connection between gender and care as it has historically developed, and I will show how this connection continues in Irigaray’s work on sexual difference and how it is related to ethical decision-making.

When care is considered a feminine ethic, as in Noddings’ work, care becomes associated with the gender that has historically had less power and influence on society. When an ethic of care is described in terms of a woman’s nature or duty, caring-about others may be interpreted as a moral requirement for women. Unless limits are understood as part of an ethic of care, self-sacrifice could result in harm to both the provider and patient. Later I will discuss how Irigaray’s work on sexual difference allows us to care-about others while lessening the possibility for harm.

Nel Noddings’ Interpretation of an Ethic of Care

Nel Noddings’ 1984 book, Caring: A Feminine Approach to Ethics and Moral Education, has generated much discussion about the validity of an ethic of care. The dialogues and concerns that were initiated by Noddings’ work have helped develop some new ways of thinking about an ethic of care. I will discuss some of the problems with Noddings’ work, such as her use of the mother/child paradigm and her assertion that the one-caring becomes engrossed in the other. Her work does not exactly fit the framework that I have
discussed since she does not use the terms caring-about and caring-for as I have described. Noddings uses "care" to mean more than providing technical skills or caring-for. She explains that caring, as an ethical ideal, involves a subjectivity that culminates in a "deep and overwhelming joy" and a "longing for relatedness," which indicates that emotions play a significant role in her theory (1984, 6). However, she also includes other aspects of care as she distinguishes between various definitions of care, including care as a burden, as a desire, and as a responsibility for someone’s physical welfare (1984, 9). She claims that a person cannot provide physical care for another without an emotional component. Therefore, Noddings seems to combine caring-about and caring-for, as both are components in her use of the term "care."

**Motivation for caring**

What motivates a person to be a caring individual is a basic concern of Noddings and impacts how her ethic of care is understood. Noddings bases her ethic of care on a feminine natural caring and claims that the "impulse to act on behalf of the present other is innate...lies latent in each of us awaiting gradual development in a succession of caring relations" and arises because "we want to do so," like a mother for her child (1984, 83, 79). Therefore a caring relationship may be established based on a person’s natural inclination toward caring. Since she bases this natural inclination on the maternal role, I will discuss the ramifications of using the mother/child paradigm in the next section. However, this natural instinct is only the first step toward an ethical caring. According to Noddings, caring becomes ethical when we have made a judgment that caring is good
and is a step beyond natural caring (1984, 83). Noddings says that an ethical caring relationship involves the one-caring recognizing that the relationship is good, and that part of the development of the innate caring involves being responsive to caring situations.

To achieve an ethical caring, a person must be able to recognize a caring situation. One of the ways that Noddings describes how an ethical caring develops is by remembering how it felt to be the recipient of care in the past. The problem with Noddings' emphasis on this learned or remembered ethical caring is its basis in the memory of experience. However, she does not account for the varieties of experiences among different people. For example, it might be difficult for a person to develop ethical caring if that person had experienced child abuse or abandonment. Further, all people do not share the same experiences or expectations of motherhood, where Noddings claims our experience of caring is developed. Noddings appears to base her explanation of an ethic of care on a memory of caring that may address only those privileged to have had past caring experiences.

While acknowledging that there are problems inherent in the use of memory to recognize caring, Noddings' explanation is plausible in cases where there are positive memories of caring. To explain how a person uses a positive memory of caring to develop ethical caring, Noddings introduces what she describes as a motivational shift. She states that when a person is a participant in a caring relationship, that person may experience a
feeling of goodness that is elicited by both caring-about another person as well as receiving care. The memory of the goodness that was created in a caring relationship could be used as motivation for future participation in a caring relationship. For example, a person may remember a caring relationship that was established with a teacher in elementary school, and then use the memory of that feeling of goodness to become the motivation for future caring\textsuperscript{14}. The motivational shift created by an earlier memory of caring can also become a part of our pre-act consciousness. Therefore, we can learn to care by remembering a past experience, and then consciously apply what we previously learned to future endeavors. We can be motivated from a previous caring relationship to change our actions consciously.

Noddings' conceptions of a motivational shift and a pre-act consciousness, which are based on a recognition of the goodness of caring relations, can be used in the health care setting. Noddings' work could be used as a tool to increase the possibility of caring-about those around us, such as patients, who are not bound by "chains of caring," such as family or friends (1984, 47). Many persons who enter the health care professions acknowledge a sense of caring that Noddings would call natural caring. In fact, many applicants to nursing, physical therapy, and medical school voice their desire to care-for and care-about persons. However, as in any social setting, health care providers cannot always rely on their natural caring attitude. There are often occasions throughout society and especially in health care when we are forced to interact with others with whom we would prefer not to if we had the choice. For example, it is often difficult to care-about
patients who are overly demanding or who are threatening or insulting toward health care providers. Even in situations where patients are particularly difficult or disagreeable, health care providers have an obligation to care-for these patients. Health care providers then may decide whether to extend their caring to the level of caring-about a difficult patient. An awareness that a patient would benefit from caring-about must arise so that a decision can be made prior to interaction with the patient. A health care provider could use a previous positive caring experience to motivate a caring attitude so that a pre-act decision could be made to care-about a certain patient in addition to caring-for that patient. Using Noddings’ ethic of care, this would elevate the caring from a natural to an ethical level.

Feminist ethicists often emphasize the importance of responding to the situation at hand, including attention to the emotional response\textsuperscript{15}. An example of using Noddings’ motivational shift and pre-act consciousness would be in a situation where a patient is aggressive and may arouse feelings of anger in the health care provider. If the provider can remember a previous positive caring experience, then the motivational shift would be toward caring-about, and a pre-act consciousness decision could arise to care-about the patient. Then the provider could determine the sources of both the patient’s and the provider’s emotions so that an appropriate responsive action could be determined in a thoughtful manner. If the emotional response to a situation, such as anger, is analyzed prior to an action, often a specific situation is found to be causing the problem, such as a patient having to wait for an extended period for a treatment, and a pre-act decision to
care-about the patient could arise. On the other hand, if the patient is abusive and hostile, a health care provider may only be able to care-for the patient as a minimum without an emotional caring-about. In a health care institutional setting, withdrawal from unpleasant or even abusive situations is often not a possibility, but caregivers are obligated to provide care-for patients even if they cannot find a motivation to care-about certain patients. Noddings’ ethic precludes withdrawing the emotional component in a caring situation. Later I will argue that it is necessary to be able to withdraw from harmful situations, and therefore limitations are needed on an ethic of care.

The one-caring often receives a reward or benefit from the realization of the goodness of relatedness in the form of joy. This joy can serve the vital purposes of "sustaining" the one-caring as well as allowing a person to recognize the importance in being connected to others (Noddings 1984, 144). Therefore, when joy is experienced as a result of caring, it reinforces the motivational shift and serves as stimulation for future caring attitudes. It must be acknowledged that caring-about persons can also result in negative feelings, such as rejection or disappointment, if the caring being offered is unwanted. Anger could also be evoked if the one being cared-about reacts in a negative way. However, Noddings’ discussion of joy as motivation is based on instances of caring situations in which the caring offered is accepted and the one-caring has a positive emotion of joy.

The idea that joy is generated by caring relationships can explain how in health care
settings a caring attitude, or lack of one, can become prevalent in the environment. As persons experience the joy of working in a caring environment, the consciousness of the goodness of caring relationships overflows to others. My concern is that when there is little or no joy experienced in a health care setting, the patient care is then reflective of that lack of joy, and patients are merely cared-for and not cared-about.

**An ideal or an obligation**

According to Noddings, a natural caring can become an ethical caring when a person makes the moral decision to enter into a caring relationship. Care becomes ethical as we "meet the other morally" as a result of natural caring, a response which comes "out of love or natural inclination" (1984, 4). She states that natural caring is an ideal but not obligatory. As caring becomes ethical, Noddings claims that it then becomes obligatory. However, she continues to refer to caring as both an ideal and an obligation. Part of the problem with being able to determine which normative level Noddings is using is due to her broad description of care. Her combining of what I have described as caring-for and caring-about makes it difficult to separate what part of Noddings' ethic of care actually is an ideal and which is obligatory. Since she claims that an ethical caring is an obligation, it becomes more important that specific limitations are placed on it.

**The mother/child model**

Noddings argues that her work is a necessary corrective for an ethical tradition based within the "language of the father...such as justification, fairness, and justice," and that
the mother’s voice has been silent" (1984, 1). Gilligan’s work influenced Noddings' claim that an ethic of care is a feminine ethic, and I will address how this claim has limited the understanding of an ethic of care. Noddings sets an ethic of care in opposition to an ethic of law and principle, which she claims are based in a detachment that is supposed to promote fairness\textsuperscript{17}. Noddings argues that an ethic of care is morally more sound than principlism because it is grounded in relationships and takes into consideration the specific situations of the persons involved in moral conflict and promotes a more individual concern. Her description of principlism as detached and abstract is different from the one that I will present in chapter three. However, Noddings is not the only proponent of an ethic of care who categorizes principlism in this way\textsuperscript{18}. Since I will discuss principlism in more detail in the next chapter, I will not address it specifically now. Unlike Noddings, I am not placing an ethic of care in opposition to principlism and will describe in the final chapter how these ethical theories need to work together, especially when ethical conflicts arise that involve relationships.

Gender is prominent in Noddings’ ethic of care, especially when she uses the mother/child relationship as the paradigm for caring. One of the reasons the mother/child model is problematic is that it cannot be adequately applied to health care relationships. First, the mother/child relationship is an unequal relationship in which there are different levels of authority\textsuperscript{19}. While patient/provider relationships may be unequal in the level of knowledge about the medical aspects of the patient’s condition, the relationship usually involves two autonomous persons. The model of a child as one
party in the relationship would be detrimental in health care in which the patient and provider should share in decision-making. The mother/child model would promote the parental mode of relationships from which paternalism arose. Over the last few decades ethicists have worked to describe the dangers of paternalism in patient care, which is acceptable only in special and limited situations, as in a case in which a patient without family is incompetent or when a patient firmly requests that the caregiver make the ultimate decision. The mother/child relationship, instead of representing a caring relationship, could lead to a regression into paternalism, which reinforces the inequality of power in the relationship.

Noddings' model of mother/child relationships does not address moral issues that arise from relationships that are ethically equal. Trying to place a relationship within a category of equal or unequal is difficult because there are many issues, such as age, education, and clinical experience that influence the relative equality of persons. Furthermore, relationships between two persons include multiple variables, including whether the persons are friends, strangers, or some hybrid of the two, such as work colleagues. Relationships in health care may fall within any of those groups, for patients are often strangers, yet intimate relationships may be formed. While Noddings should clarify her use of the terms "equal" and "unequal," she does not seem to be referring to the inherent worth of persons or implying that one person's life is of more value. She uses the terms more to describe an external situation in which one person's position in society or an institution has more authority. It is difficult to describe a relationship that
is completely equal, since even between friends and colleagues there are instances of inequality. There are too many unknown factors between strangers to assume complete equality, yet in the patient/provider relationship, one should assume an ethical equality grounded in the autonomy of persons.

Noddings' use of the maternal also promulgates a continuing dichotomy of societal function by gender. In her model the mother as the one-caring marginalizes the caring work of men, especially in the health care environment. Although in chapter three I will describe a hierarchy among health care providers that involves gender, it is important to emphasize that caring-for and caring-about patients is performed by both genders. When Noddings uses the mother/child relationship as the model, she overlooks the value of the father/child relationship as well as many caring relationships that occur frequently in health care.

Noddings refers to Carol Gilligan's work when she claims that caring is generally more natural for women than men. However, she uses Gilligan's work incorrectly when she tries to justify a distinct separation of the genders with her work. Although Gilligan found that her female subjects used care in moral reasoning more often than justice, she also acknowledged that both genders were capable of either moral discourse. Noddings speaks of feminine and masculine approaches to ethics as if they clearly can be distinguished by gender. Noddings asserts that "women are better equipped for caring than men," and therefore, she determines that an ethic of care is a "feminine ethic."
This assertion is difficult to accept because in the health care environment there are many examples of ethical caring behaviors exhibited by both genders. Behavioral differences between the genders seem more related to what has been valued as a society and what has been learned to be feminine and masculine rather than to which gender is innately capable of a certain type of moral reasoning. Noddings’ division of the genders and her designation of an ethic of care as a feminine ethic does not appear to fit with the reality of human experience.

While Noddings claims that an ethic of care is a feminine ethic, she may be doing care a disservice by limiting an ethic of care to one gender, especially the one that has historically been valued less. Luce Irigaray’s work on sexual difference is pertinent to the discussion of the maternal as the paradigm for caring. She describes how the female body has been devalued and explains how sexual difference can be celebrated without trying to place the genders into opposition or a hierarchy. This is particularly relevant for health care relationships that include male and female caregivers.

The self in a caring relationship

Noddings describes two entities involved in a caring relationship as the one-caring and the cared-for. According to Noddings, a caring relationship is initiated with caring for the self. However in her description of the meeting of the other, the one-caring moves away from oneself to become "engrossed" in the needs of the other. She claims that the self is enhanced when it cares for others. This is one of the major weaknesses in
Noddings' account of care. She appears to contradict herself in wanting to care for the self but also in promoting a move away from oneself. Noddings' portrayal of the self becoming engrossed in the other is a dangerous construction for women who have been taught to value the other in a self-sacrificial manner. Women seem especially prone to care for others at their own expense because historically women have been expected to be self-sacrificial, especially with respect to their children and family. Further, the idea that caring for others involves self-sacrifice has been fostered historically by Protestant theologians, such as Anders Nygren and Reinhold Niebuhr (Andolsen 1994, 147)\textsuperscript{20}. Women historically were taught that self-sacrifice is expected and honorable. Noddings' account does not encourage women to develop and maintain their own sense of self without becoming totally engulfed in another's world.

In Noddings' explanation of care, the self appears to become lost once it becomes "engrossed" in the other. She describes how the one-caring steps out of herself and into the other's frame of reference (1984, 24). As various other feminists have noted\textsuperscript{21}, Noddings' description of the one-caring's engrossment in the other is a dangerous relationship that allows for further exploitation and oppression of women. Noddings denies that her ethic of care is agapistic, stating that the "one-caring must be maintained...must be strong, courageous, and capable of joy" (1984, 100). However, Noddings' description of the relationship between the one-caring and the cared-for is too unidirectional and risks that the one-caring may become depleted. When she uses the term "engrossed in the other," Noddings gives the impression that the self becomes
contingent on the welfare of the other. A regard for the other's needs through caring seems a more appropriate description than engrossment. By emphasizing the aspect of engrossment, Noddings undermines her concern for the self in the relationship.

How people relate to each other is affected by how each person in the relationship perceives the self and the other. I will argue that in order for relationships to be healthy rather than exploitative or harmful, there must be a strong sense of the self when caring-about the other. If one is to enter into a caring relationship with another, it must originate in a self-recognition of one's own strengths and weaknesses. This recognition of one's self develops as a person learns from interactions with others and "gains perspective" of the self in society and the world (Gilligan 1986, 250). As a person develops this awareness of who and where the self is in relationship to others, a person becomes more capable of caring-about others because one is more sensitive to the others in a relationship. When a sensitivity to the other is recognized, a person can be more attuned to a person's physical and emotional needs.

Luce Irigaray's work on how woman's self has been constructed from the mirror image of man provides a basis to critique Noddings' self-other relationship. According to Irigaray, woman has been the mirror that allows man to see himself. Woman can never see herself except through the reflection of him, for "woman cannot place herself as an object for herself" (1993, 69). The importance of woman's recognition of self will be discussed when Irigaray's work is presented. I will explain how woman's voice is
eliminated when the woman's self can no longer express itself. Irigaray's work will help to explain why self-sacrifice is detrimental in a relationship.

Maintaining a strong sense of self is of particular importance in health care relationships between caregivers and patients. The one-caring for patients is at risk of becoming overcome by the needs of patients if caring-about is unlimited. According to Joan Tronto, "a morally mature person understands the balance between caring for the self and caring for others" (1993, 249); yet health care providers often find this balance difficult to maintain. Although patients enter institutions of health care because they need to receive care, those providing care need to recognize when caring-about patients becomes detrimental to themselves and the patients. Because health care providers want to give optimal care to patients, they may find that caring-about patients can lead to being overwhelmed by their emotional and psychological demands. This occurs when the sense of self becomes engrossed with the one needing care and one's own sense of moral agency becomes diminished.

Providing an emotional level of caring in health care can at times be dangerous. When caregivers become too self-sacrificial, for example when they often choose to stay late with a patient rather than attending to their own needs, they may suffer harm from a deprived personal life. This deprivation could translate into negative effects upon patient care if the caregiver does not recognize that the self also has needs. A more serious form of self-sacrifice occurs when a caregiver chooses to place personal health and well-being at risk, for example by not using proper infection control precautions with
infectious disease patients. Also if a health care provider becomes emotionally depleted by extensively caring-about a certain patient, other patients may not receive the attention that they need.

It is difficult to determine when too much caring-about becomes self-sacrificial. According to Alisa Carse, health care providers may at times need to embrace an appropriate detachment rather than a caring relationship with patients (1996, 23). However, if detachment is promoted in health care and caring-for alone results, the ethic of care becomes an ethic of beneficence. Therefore, it is necessary for health care providers to be able to recognize when they have exceeded the ideal of an ethic of care that includes caring-about others and have become self-sacrificial. Being attentive to patients' needs and caring-about them is exhausting work that entails expending emotional energy. Providers of health care must balance their own needs with the needs of their patients. Health care providers must have a strong sense of self so that they understand when they begin to become emotionally depleted on behalf of their patients. Care must first be directed toward the self and then toward others in need.

Noddings' construction of an ethic of care in which the one-caring becomes "engrossed" in the cared-for promotes an ethic of care that is unhealthy and dangerous especially to women. It appears to promote the patriarchal image of woman as sole nurturer who gives so much to others that her sense of self suffers. Using Irigaray's work on sexual difference, I will emphasize the importance of maintaining a recognition of the self and
the other without a collapse of the two into one. It will be a dynamic relationship which will emphasize the value of difference in forming a caring relationship.

**Reciprocity in care**

According to Noddings, once the one-caring is engrossed in the other, a response from the "cared-for" is necessary for an ethical caring relationship to be established. She claims that this recognition, or reciprocity, is what fulfills the one-caring and establishes an ethical relationship. Even though Noddings claims that this reciprocity is necessary, her work continues to include elements of self-sacrifice because the one-caring must become engrossed in the other prior to knowing if there will be any reciprocity. Further, reciprocity in Noddings' presentation is based on the mother/child model of acknowledgment in which only a recognition by the child of the care being given by the mother is needed and not an emotional response. This definition has been criticized by feminists as not being a truly reciprocal relationship. Hoagland claims that we need to expect caring in return from others for true reciprocity. However, in reality we cannot be responsible for another's action in response to our caring. As autonomous human beings, we have the ability to offer care to another regardless of the response. Even if caring is not reciprocated by the other, at least a caring relationship has been initiated. If Hoagland were correct that a caring response is expected and necessary, it would be difficult to extend a caring attitude toward strangers and nonintimates. This would especially pose a problem in health care situations in which care is usually provided to persons previously unknown who may be unable to even acknowledge the
care offered to them.

In situations where caring is not acknowledged or reciprocated, caring-about another may establish a basis for a future reciprocal caring relationship to develop. Further, if the health care provider has a strong sense of self, providing care would not need overt recognition to validate the care being offered. While reciprocity in a caring relationship may strengthen a relationship, it is not necessary, or even possible, in many situations. We can extend care to those unaware of us or incapable of responding without diminishing the caring nature of the relationship. Even though a response of caring in return from the other possibly would enhance a caring relationship, I contend that caring-about another, even without a response, establishes the basis for a caring relationship beyond the obligatory caring-for. In such a scenario, the value of the one-caring’s offer of care is not contingent on the other’s response.

Noddings claims that reciprocity is necessary in a caring relationship. While overt reciprocity between the caregiver and the patient may produce a caring relationship, I argue that it is not necessary. If we demand a response from the patient, we may be limiting the potential for the growth of a caring relationship. Even if the offer of care is not acknowledged, the one-caring may be able to derive a sense of goodness and recognize an emotional component involved in being the one-caring. Provided the one-caring maintains a sense of self which is not depleted by constantly being the one-caring without ever being the recipient of care, the caregiver is in a position to benefit even
without reciprocation. By providing care to another, an opportunity is established for a future caring relationship to develop. If the one-caring recognizes the goodness of caring for another, that emotion could become the motivation for future caring. Therefore, the one-caring must recognize the value of self and of caring for another without dependence on the other's response.

Necessary limitations on the ethic of care

In health care relationships involving patients, the one being cared-about, or even just cared-for, is often physically unable to respond to the caring provider. Often the patients or the families are emotionally unable to acknowledge, or only minimally able to respond to a health care provider who has been caring-about the patient. When there is no such acknowledgment, or even a rejection of care, the one-caring must decide to continue caring-about the patient or withdraw to a caring-for level.

Once a caring relationship has been established, Noddings contends that the one-caring cannot ethically withdraw from the relationship. She explains that when the one-caring has committed to a relationship that has been acknowledged by the other, it would be unethical for one to withdraw because it would leave the relationship in a state of deficiency. This depiction of an ethical relationship does not seem appropriate to health care patient/provider relationships. As I described above, patients often do not or cannot respond to the one-caring. According to Noddings, without this response there is no ethical relationship established. However, I have shown that in health care a relationship
could be established without an overt or positive response from a patient. Therefore, as opposed to Noddings’ description based on the mother/child model, a health care provider who cares-about a patient needs to have the options of continuing to provide the caring-for, caring-about, or to withdraw from the situation if the offer of care is rejected. If the health care provider determines that appropriate and ethical care cannot be provided and wants to withdraw from the care of a patient, the health care provider must make arrangements for the patient to receive care from another caregiver or if that is not possible, the provider must continue caring-for the patient in order to fulfill the ethical role obligations.

In health care, providers often care for patients who are abusive or who may exhibit morally questionable behaviors, for example, when dealing with prisoners. There are occasions when the one-caring must withdraw from abusive, oppressive, or unhealthy relationships. If a situation becomes self-sacrificial to a point of harm to the one-caring, it would not enhance the ethical value of the relationship to continue it, because it would be detrimental to one of the members of the relationship. If the health care provider continues to be depleted by abusive or nonreceptive patients, there is a possibility that the provider would become less able to offer that care to future patients or may begin to avoid further contact with the patient who does not respond to the caring. Noddings claims that the offer of care to the other must be nonjudgmental, yet it would be dangerous and unrealistic to both parties in the relationship to promote an unconditional caring of another without protecting the self in the process. The potential for harm arises
if the one-caring is not allowed ethically to judge the appropriateness of continuing the relationship.25

Summary

The purpose of this chapter has been to examine the ethical basis of the patient/provider relationship. I described the role of both physician and nonphysician health care providers in patient care and the obligations associated with those roles. Although the professions of medicine, nursing, and physical therapy have distinct areas of expertise in the health care environment, they also share many of the same general and specific obligations to their patients. By showing how the professions have developed historically, I have been preparing for the discussion in the next chapter that will focus on interprofessional relationships. However, before embarking on that discussion, I thought it necessary to describe how these three groups have similar ethical obligations in patient care. Part of what makes the patient/provider relationship different from other business relationships is the role of the vulnerable patient. I discussed the importance of patients being able to trust their health care providers to provide competent care as well as being committed to their well-being.

The final component of the patient/provider relationship involves the emotional aspect involved in providing health care for ill persons. While there is an obligation to care-for patients, the more emotional level of caring-about patients is an ideal that must be subjected to certain limitations. As I move to the relationship between health care
professionals, the relationship between self and other will continue to be a consideration.

Further, the role of gender in health care relationships will be further explored since gender is a factor in both patient/provider and interprofessional relationships.

NOTES

Chapter Two

1. There is an ongoing debate regarding the term to be used regarding persons who seek health care. These persons have been referred to as patients, clients or customers. It is understood that all persons who enter the health care system are not sick and some may be seeking preventive care. Since I am focusing on those persons who are not well, I will use the term "patients" to describe those who become part of a health care relationship.


In The Nature of Suffering and the Goals of Medicine (New York: Oxford University
Press, 1991), Eric J. Cassell explains that the "effect of the doctor on the patient (and vice versa) is always present" and can affect the patient's response to a treatment "in a manner similar to the placebo effect" (120).

5. In chapter two I will further discuss how detrimental this idea of self-sacrifice has been especially to women.

6. While patients have obligations toward their health care providers, such as providing honest information, that aspect of the patient/provider relationship will not be addressed in this work.

7. Diana T. Meyers claims that there is "the possibility that human relations can involve deep and special emotional bonds that have a moral significance" (142) in "The Socialized Individual and Individual Autonomy: An Intersection between Philosophy and Psychology" (139-153) in Eva Feder Kittay and Diana T. Meyers, Women and Moral Theory (Totowa: Rowman and Littlefield Publishers, 1987). I will discuss how becoming emotionally connected with a patient may influence a health care provider's decisions. In the same collection of essays, Virginia Held acknowledges a "component of feeling and relatedness between self and particular others" (118) in "Feminism and Moral Theory" (111-128). I will explain how in health care, relationships may form that involve an emotional component.

8. In describing an ethic of care, the focus often centers on the importance of relationships. Tom L. Beauchamp and James F. Childress, in Principles of Biomedical Ethics, 4th Ed., (New York: Oxford University Press, 1994), describe caring as "care for, emotional commitment to, and willingness to act on behalf of persons with whom one has a significant relationship" (85). They claim that an ethic of care emphasizes "traits valued in intimate personal relationships, such as sympathy, compassion, fidelity, discernment, and love" (85). Further, in her article "The 'Voice of Care': Implications for Bioethical Education" in The Journal of Medicine and Philosophy (16, 1991): 5-28, Alisa Carse describes an ethic of care as the "importance of concern for the good of others and community with them, a capacity for imaginative projection into the position of others and situation-attuned responses to others' needs" (18). This description of an ethic of care draws attention to the relational aspect of an ethic of care in which each situation and person is considered within its own context. Nel Noddings defines 'relation' as a "set of ordered pairs generated by some rule that describes the affect - or subjective experience - of the members" (3-4) in Caring: A Feminine Approach to Ethics and Moral Education (Berkeley: University of California Press, 1984). One of the premises of Noddings' presentation of an ethic of care is that "relation will be taken as ontologically basic and the caring relation as ethically basic" (3). Therefore, in Noddings' ethic of care, we are defined by our relationships with others, and our ethics is grounded in a caring response to the other. The response that Noddings is advocating is a personal one which takes into consideration the other's particular situation.

J. Kellenberger, in Relationship Morality (University Park, PA: The Pennsylvania State
University Press, 1995), distinguishes relationship morality from a feminist morality of
care. He acknowledges that there are several similarities, including the emphasis on
relationships as morally ultimate and that we attain a sense of caring for others.

9. Caring-for and caring-about have been described and categorized in various ways.
These are a few examples of descriptions of care. Alisa Carse and Hilde Lindemann
Nelson explain that "'caring about' presupposes a position in value theory." Further,
these feminist writers claim that "caring for" is "an activity involving moral skill" (29)
in "Rehabilitating Care," Kennedy Institute of Ethics Journal 6, no. 1 (March 1996): 19-
35. Edmund Pellegrino distinguishes various forms of care including "care as
compassion," caring as "doing for others," taking "care of the medical problem," and
to "take care" of skills for patients (11-12) in "The Caring Ethic: The Relation of
Physician to Patient," in Bishop, Anne H. and John R. Scudder, Jr., eds., Caring,
Curing, Coping (The University of Alabama Press, 1985). Bernice Fisher and Joan
Tronto also describe four components of caring as "caring about, taking care of,
caregiving, and care-receiving" (40) in "Toward a Feminist Theory of Caring," in Emily
K. Abel and Margaret K. Nelson, eds., Circles of Care: Work and Identity in Women's

10. Carol Gilligan emphasizes that an ethic of care involves a "connection, theorized as
primary and seen as fundamental in human life" (122) in "Hearing the Difference:
Theorizing Connection," Hypatia 10, no. 2 (Spring 1995): 120-127. Care is described
as a process involving the experiences of persons which must be considered on an
individual level by Joan Tronto in "Care as a Basis for Radical Political Judgments,"
Hypatia 10, no. 2 (Spring 95): 140-149. Also describing an ethic of care as a process
as opposed to a fixed state are Eve Browning Cole and Susan Coultrap-McQuin,
"Toward a Feminist Conception of Moral Life," in Eve Browning Cole and Susan
Coultrap-McQuin, Explorations in Feminist Ethics: Theory and Practice (Bloomington:
Indiana University Press, 1992, 4). They describe this process as involving the one-
caring as engaging with the cared-for and trying to understand the other's situation.
Further, the one-caring learns to care for the self in the process (3-4). In the same
collection of essays, Patricia Ward Scaltsas discusses feminist ethics and how the
"demands of a situation, [are] discovered through attention to it" (16) in "Do Feminist
Ethics Count Feminist Aims?".

11. While I argue that caring-about is an ideal, others claim that caring-about involves
obligation. Rita Manning explains that there is a general obligation to be a caring person
which arises from the "human capacity for caring interaction" (69) in Speaking from the
Heart: A Feminist Perspective on Ethics (Lanham, MD: Rowman and Littlefield
Publishers, Inc., 1992). She says that an obligation to care "involves acting in some
appropriate way to respond to the needs of persons and animals" (62). Alisa L. Carse
and Hilde Lindemann Nelson also describe a "moral responsibility to understand and
attend to needs of others" in "Rehabilitating Care," Kennedy Institute of Ethics Journal
12. Some feminists like Annette Baier are able to distinguish other voices than those of care or justice. While she claims that women have not produced a theory that is a "coherent near-comprehensive account," she believes that a "guiding motif" of a woman's moral theory would be an "ethics of love" when combined with obligation which would produce "appropriate trust" (53, 55). ("What Do Women Want in a Moral Theory?" Nous [19, no. 1, March 1985], 53-63).

13. The debate that assigns a gender to either a care or justice orientation of moral reasoning is often subtle and dangerous. If essentialism is promoted based on sexual specificity, social inequality would continue because of persistent claims that women are biologically inferior or at least unsuited for certain roles and experiences. In the early 1970's, Vivian Gornick expressed her concern about sexuality being a determinant of social worth when she said that "even in a generation when man has landed on the moon - woman shall remain a person defined not by the struggling development of her brain or her will or her spirit, but rather by her childbearing properties and her status as companion to men who make, and do, rule the earth" (xii). (Vivian Gornick and Barbara K. Moran, eds., Woman in Sexist Society: Studies in Power and Powerlessness, [New York: Basic Books, Inc., Publishers, 1971]).

These early debates were necessary for feminists to lay the foundation for the more current work on oppression, as in the following works. In Moral Boundaries: A Political Argument for an Ethic of Care, (New York: Routledge, 1993), Joan Tronto is concerned that the "debate between essentialism and constructivism...siderailed what should be the central concerns of feminist theory," which are the oppression and devaluation of women (13). Kathryn Tanner also states that "feminist ethicists who stress the differences between women and men unintentionally feed the stereotypes that harm women and buttress arguments used to justify their oppression (173), ("The Care That Does Justice: Recent Writings in Feminist Ethics and Theology," Journal of Religious Ethics, 24, no. 1, Spring 1996, 171-191). Sidney Callahan accuses Gilligan of making "exaggerated claims...for the importance of gender and automatic effects of early nurturing" (195) in Good Conscience: Reason and Emotion in Moral Decision Making, (San Francisco: Harper, 1991).

14. Noddings does not address the possibility that the memory of an unpleasant experience could also be motivational. A person may use the memory of a previously painful or uncaring relationship as a reminder of an emotion that the person would not want to reproduce in a future relationship. While acknowledging that this type of situation could occur, I will focus on the memory of previous caring experiences.

15. This awareness of the others' situation via being attuned to one's relationships has been called "attention" by Simone Weil and "love of others" by Dorothea Soelle in her The Strength of the Weak: Toward a Christian Feminist Identity, translated by Robert Kember and Rita Kember, (Philadelphia: The Westminster Press, 1984). Soelle further explains that Weil's "attention" to the "reality of another person" occurs due to "a critical, negative force that blocks out our prejudices, expectations, and preconceived
notions so that we become empty and ready to perceive what another person is expressing" (34). While it appears that we are able to separate our responses to different persons, I question whether we can actually block out our negative preconceptions effectively.

16. Noddings describes joy as an emotion evoked by the goodness of a caring relationship. Joy is a motivation for future caring. In contrast, Levinas discusses jouissance as a much broader term that encompasses much more than physiological or emotional responses to outside forces. Levinas writes in Totality and Infinity, (Pittsburgh: Duquesne University Press, 1969), that enjoyment of life is happiness which is independent. While enjoyment is pre-ethical for Levinas, he also recognizes as a part of life that there are needs which should be fulfilled (114-115).

17. In "The Ethic of Care vis-a-vis the Ethic of Rights: A Problem for Contemporary Moral Theory," Hypatia 9, no. 3 (Summer 1994): 108-131, Joy Kroeger-Mappes criticizes Annette Baier's attempt at mediating rights and care with justice. She claims that by continuing to address care and rights as two separate domains, we risk continuing a hierarchical system in which a traditional male bias toward rights will allow subordination of women by reinforcing the existing flawed system. This would occur because caring, she says, is "perceived as supererogatory for most men, [and] is perceived as obligatory for most women" (113). Rather, she supports care and rights as one system in which care is "necessary" for rights (124).

18. Rita C. Manning criticizes the utilization of principlism based on methodological concerns in Speaking from the Heart: A Feminist Perspective on Ethics (Lanham, MD: Rowman and Littlefield Publishers, Inc., 1992). She claims that principles are too abstract and that their use limits our "moral imaginations" which would allow us to pay "attention to the particulars of a situation" (89). Patricia Ward Scaltzas draws our attention to broader feminist concerns which include critiquing abstraction which is associated with principlism (16) in "Do Feminist Ethics Counter Feminist Aims?" in Explorations in Feminist Ethics: Theory and Practice, ed. Eve Browning Cole and Susan Coultrop-McQuin (Bloomington: Indiana University Press, 1992).

19. In "Some Concerns About Nel Noddings' Caring," in Hypatia, 5, no. 1, (Spring 1990): 109-114, Sarah Lucia Hoagland challenges Noddings' use of unequal relations as a basic representative of an ethic of care because unequal relationships are not only a result of a perception of differences in knowledge or abilities, but she cautions that unequal relations are often based on a perception of the other person being less competent to make decisions and "encourages incompetency" (112).

20. Barbara Hilkert Andolsen, in "Agape in Feminist Ethics," in Lois K. Daly, ed., Feminist Theological Ethics: A Reader, (Louisville: Westminster John Knox Press, 1994), 146-159, describes the historical development of the self-sacrificial component in Protestant teachings. She quotes Margaret Foley as saying that Protestant teachings of agape were often interpreted by women as sacrificing themselves "for the sake of men"


23. Although I believe that she is referring to caring-about in a reciprocal relationship, Noddings uses the term "cared-for" to generally mean the person receiving the care.

24. Hoagland criticizes Noddings’ definition of reciprocity as "infant non-reciprocity-beyond acknowledgment" as having "no real expectation of an intimate" (106). In "Caring and Evil," *Hypatia* 5, no. 1, (Spring 1990, 101-108), Card agrees with this criticism of Noddings’ description of reciprocity as being too unidirectional. She claims that reciprocity occurs "only if equivalent in value" (1990, 106).

25. Barbara Houston, in "Caring and Exploitation," *Hypatia* (95, no. 1, Spring 1990), 115-119, is concerned that women may equate their moral worth with their capacity to care for others. She believes that the moral worth of persons is "ambiguous," and that we should be able "to rule out undesirable caring relations" (116, 118).
Chapter 3

Interprofessional Relationships

Introduction to the Importance of Interprofessional Relationships

While the patient/provider relationship is primary in the health care environment, I will argue that the relationships among health care providers are also important because they involve ethical ramifications for patient care. Since I have already described the patient/provider relationship and some of the ethical issues involved in that relationship, I will now describe some of the common interprofessional relationships in health care and how the traditional ethical methodologies of principism and casuistry have not adequately addressed the ethical concerns involving these relationships. I will argue that interprofessional relationships have not received the necessary attention due to the way that health care ethics has traditionally been studied with the focus being on the role of the physician and the physician/patient relationship. Further, I will argue that there are ethical issues that arise between health care providers, and I will discuss how these issues affect patient care in the final chapter. The traditional modes of ethical analysis, such as principism and casuistry, have been used to study crisis situations, but as I will describe, they are not sufficient to address ongoing issues in health care that arise within relationships.

I will describe how principles have been interpreted and applied narrowly to health care dilemmas and how they have focused on decisions being made by a single voice that is
usually a physician's. Interprofessional relationships are affected by institutional and
historical hierarchies and the resulting claims of authority have ethical implications for
both the patient and provider. These issues of authority are the types of ongoing and
pervasive ethical concerns that principlism and casuistry have not adequately addressed.
Principlism and casuistry have been insufficient in addressing the ethical issues that are
inherent in interprofessional relationships not only due to the limitations of the
interpretation and application of the principles, but also due to the manner in which cases
are chosen for study. Later in this chapter I will discuss some of the historical sexual
biases and divisions in health care based on gender that affect interprofessional
relationships. Irigaray's work on masculine and feminine discourse and the relationship
of object to subject is pertinent to the traditional role that gender plays in health care.

Description of Health Care Relationships

In chapter two I addressed the patient/provider relationship from the ethical perspective
of obligations based on the health care provider's role and on the emotional component
relating to care of the patient. This chapter will focus on why interprofessional
relationships have not been studied sufficiently using the traditional methodologies of
principlism and casuistry. After I provide a description of the relationships to which I
will be referring, I will discuss the deficiencies inherent in principlism and casuistry in
analyzing the ethical aspects of these relationships.

Relationships among health care providers are complex and affected by many factors,
including those associated with the institutional setting and some directly related to the persons involved in the relationships. I will begin this section with a composite description of relationships among nurses, physicians, and physical therapists as I have witnessed them for more than twenty-four years in hospital settings. This description of these relationships is not meant to be comprehensive since there are too many variables that can affect specific relationships. Rather, this should serve as a descriptive basis upon which to be able to discuss the ethical concerns that arise within these interprofessional relationships. Some variables, such as ownership of the hospital and its for-profit or nonprofit status, involve institutional issues that this work will not address. Further, I acknowledge that individual health care providers may behave differently from the composite picture that I will describe because specific individuals vary in their responses to situations and relationships. It is provided as a basis from which to begin a discussion of the ethical relevance of these relationships that tend to follow certain traditional patterns. I will use this composite description of these relationships, using the categories of structural and dynamic elements as a basis of analysis of the relationships. It is necessary to first describe the relationships since I want to discuss how specific ethical issues are involved in interprofessional relationships, especially with respect to patient care.

Relationships in health care often involve several persons who have professional responsibilities for the same patient. There is always a physician involved in the care of the patient because a patient must be referred to a hospital by a physician. I have
chosen nurses and physical therapists as two groups who have ongoing patient care responsibilities and form relationships with physicians and each other. I will begin with a brief description of how physicians interact with nurses and physical therapists and then describe how relationships among these groups are developed. Physicians have traditionally held the position of authority in hospitals. They have specific powers, such as admitting and discharging patients, writing "orders" in the medical record, performing invasive procedures, and prescribing drugs. Their medical education has prepared them to diagnose disease and perform specific technical skills, such as surgery. Because physicians historically have been the point of entry into the health care system, they have the role of coordinating the patient's care and have the authority to direct other health care providers to provide certain services to patients. Most physicians have offices located away from the hospital premises where they see outpatients and travel to the hospital, or several hospitals, to make rounds to see their inpatients once or twice a day. Except in teaching hospitals, physicians generally spend less time in the hospital than the other health care providers, such as nurses and physical therapists who are usually employed or contract with the hospital and have offices or departments located in the facility in close proximity to patients.

After the physician has had what is usually a brief encounter with the hospitalized patient and writes a note in the medical record, the physician leaves the nursing unit, and the nurse then reassumes the position of authority. It is the nurse's responsibility to care for the patient over the course of a shift that may range from eight to twelve hours when
there may be no physicians present in the hospital. The relationship between physicians and nurses varies greatly among individuals due to differences in age, gender, race, sexual orientation, years of experience, personality, and other socio-economic factors. However, there are certain observable behaviors that seem consistent in these relationships. There are generally at least two types of relationships that can be observed: these are either a collegial type of relationship where there is an open exchange of information and concern for the patient or an authoritative type of relationship that exists when physicians give orders to nurses without acknowledging the role of the nurse in patient care. This second type of relationship seems to occur frequently in hospitals and results in a strict and reinforced hierarchical structure between the physician and nurse. Sometimes relationships between nurses and physicians are friendly and congenial, and sometimes they are formal or even antagonistic.

Physical therapists and physicians communicate most often via the written medical record. Nurses may act as intermediaries between physicians and physical therapists by relaying referrals or pertinent patient information. At times physical therapists may call physicians to communicate directly with them. Because there is less direct interaction, the physical therapist/physician relationship is usually less well-established than the one between nurses and physicians unless a concerted effort is made by the physical therapist to be available whenever the physician is in the hospital. Once a referral has been written for physical therapy, any further communication about patient care is usually initiated by the physical therapist. These relationships are as variable as the
nurse/physician relationship, and can vary from collegial to authoritative to nonexistent.

After a physician writes a request in the medical record for other services for a patient, the nurse becomes responsible for obtaining those services, including physical therapy. The relationship between nurses and physical therapists also varies. Often nurses and physical therapists work well together. This can be a particularly collegial relationship if communication is established and if concern for the patient is mutually acknowledged. However, sometimes nurses resent physical therapists who invade their nursing unit and often interfere with scheduled nursing responsibilities, such as cleaning or medicating patients. Physical therapists often treat patients without consulting the nurses who have been responsible for the patient, yet they often need nursing assistance to handle patients. Since the nurse is responsible for the ongoing care of the hospitalized patient, and the physical therapist is responsible for the rehabilitation of the patient, these two groups often come in contact with each other and may conflict over what is in the best interest of the patient. While this relationship can be one of mutual respect, it can also be strained as the two providers seem to compete for a higher level of authority with patients and with physicians.

Health care relationships vary among providers, but the historical model has placed physicians at the highest hierarchical position of authority. Although there are hierarchies among specialties of physicians, almost any person with a medical degree is considered to have authority over all other health care providers. There is no distinct
hierarchy among the other nonphysician providers; nevertheless there are ongoing struggles between the professions of nursing and physical therapy as they each strive to claim more authority over patient care as their level of responsibility for the patient increases. In an institutional setting, when physicians are not present, nurses have traditionally held the position of authority in providing on-going care for patient care. Physical therapists often provide care to patients without direct physician supervision, yet they are also placed in a lower position of authority than physicians and sometimes in a competitive position with nurses. These issues of authority and hierarchical status in the health care environment will be further discussed since they are one reason, along with gender, why principlism and casuistry have not been sufficient in addressing the ethical concerns that emanate from interprofessional relationships. Since these interprofessional relationships are developed in the midst of caring-for and caring-about patients, they affect the environment in which health care is provided to patients. In the final chapter I will describe the ethical ramifications of these caregivers' roles in relationship to patient care.

There are various elements that underlie interprofessional relationships that can be divided into structural and dynamic categories. By delineating these elements, I am further able to describe a pattern of how these health care providers relate to each other. Structural elements are those aspects of the relationship that are relatively stable or established, such as hierarchical arrangements, social factors, and gender. These factors are historically related to issues of professional authority. Dynamic elements are
those aspects that vary among persons and situations, such as the level of intimacy and trust that is developed within a relationship. After describing these elements of relationships, I will be able to describe why principlism and casuistry have not been able to sufficiently address the ethical concerns embedded in relationships among health care providers.

**Structural Elements of Relationships**

The hierarchical arrangement of the institution of health care affects the relationships among health care providers. First I will describe the historical development of the hierarchical arrangement of health care providers with the physicians being in the superior position. The historical development of the professions of medicine, nursing, and physical therapy helps explain how physicians came to hold the position of authority in health care. Some of the factors that led to the establishment of this hierarchical arrangement include the educational background and socio-economic levels of the various health care providers. I am including education as a structural element because the educational requirements of physicians, nurses, and physical therapists are institutionally and governmentally controlled. Therefore, each of these provider groups function within boundaries established and maintained as standards appropriate for each group.

Although there have been significant changes over the last few decades in the educational and clinical preparation of nurses, physical therapists, and physicians, these three groups have continued to relate to each other in the same hierarchical manner with little change.
Since the traditional system of hierarchical relationships generally has functioned to provide patients with appropriate health care, it would be inaccurate to argue that patients have not received adequate care within this system. However, I will later discuss how these hierarchical relationships may affect both the quality of patient care as well as the individual providers. The element of gender overlaps with these issues and also relates to the issue of authority.

Authority

Historically, medicine did not always enjoy the position of authority that it now claims. In the late nineteenth century the profession of medicine gained its position of authority as it changed its educational requirements and instituted licensure through state laws\(^6\). Further, medical authority grew as science was gaining a greater acceptance and medicine was becoming "objectively validated" (Starr 1982, 134-135, 12)\(^7\). As society grew to accept physicians in the role of authority in health care, physicians were also afforded more status in society in general. This escalation of authority is most evident in the powerful positions that physicians hold in hospitals.

Patients have also accepted physicians as having authority over all aspects of their health care. Part of that acceptance has occurred due to the nature of medical education in which students are encouraged to assume an air of certainty\(^8\). Since patients do not usually understand the ambiguous and uncertain nature of health care, they do not have a realistic view of the system and may begin to believe that physicians have indisputable
knowledge about their health. While the consumer of health care now has access to more medical information directly, many patients continue to rely on the judgment of the physician in making difficult decisions.

Since physicians have been the traditional gatekeepers in health care, the patient’s first contact with the health care system is usually a physician who may refer the patient to another caregiver. Patients then accept physicians as the authority over all other providers, and thus reinforce the hierarchical nature of health care. Since physicians historically have held the position of authority over all aspects of a patient’s care, at times they may conflate an organizational position of leadership with one of complete authority. When this occurs, ethical concerns may arise among health care providers that principiplsm and casuistry have not identified or addressed. For example, the question of who has the ultimate authority to make a patient care decision involves the well-being of the patient. There may be several caregivers with knowledge regarding a patient’s condition or treatment options whose voices may be beneficial in helping a patient make a decision. Since there are many health care providers with specialized areas of knowledge and who also have obligations to the patient, conflicts among providers are possible. Further, if voices of nonphysician health care providers are silenced by the authoritative voice of the physician, the patient may be deprived of alternative perspectives in their health care decisions.

The traditional female health care professions of nursing and physical therapy have
contributed to the history of the hierarchicalization of health care by practicing a tradition of deference toward physicians. The history of these fields also helps explain how hierarchies developed with physicians in the superior position. Nursing originated in the home, with women taking care of sick family members, assuming roles closely associated with housekeeping responsibilities\textsuperscript{10}. Early hospitals followed the model of the home, with the nurse functioning as the "mother" and the physician as the "father." This model contributed to women in health care being segregated into lesser pay and lower status jobs (Jameton, 1984, 40 and Tanner 1996, 178). Early in the history of nursing a division was established between nurses who provided "care" and physicians who gave advice and performed medical procedures that were associated with "curing" (Jecker 1994, 61). This separation has continued into the current health care environment even though nurses now perform critical treatments for patients and must use their knowledge and judgment to make important decisions about patient care, and physicians participate in caring relationships with patients.

Until 1973 nurses were admonished by their professional associations to follow "the physician's order intelligently and loyally," thus reinforcing that nurses should defer to the physician (Jameton 1984, 38). Nursing associations helped perpetuate the image of nurses as "handmaidens" by promoting the idea that nurses were in an inferior position in health care. Gradually, the nursing associations acknowledged the changes that had been occurring in health care since World War II. These changes were reflected in nursing education that became more scientifically based as the technological knowledge
of nurses increased. Furthermore, physicians began to spend less time in hospitals and
more in their office practices, while more acutely ill patients were hospitalized where
nurses had the responsibility to provide care for them, using ever-increasing technological
advances (Rowland 1984, 23). Gradually, nurses assumed much more of the
responsibilities for patient care decisions in hospitals, but without the explicit authority.

In 1973 the International Council of Nurses responded to these changes in the delivery
of health care by dropping the statement in their code of ethics on the obligation to carry
out physicians' orders and replaced it with the following: "The nurse sustains a
cooperative relationship with co-workers in nursing and other fields" (Jameton 1984, 38).
This statement was written to more accurately describe the nursing profession's clinical
status and working relationships with other health care providers in hospitals.
Furthermore, the American Nurses Association 1985 Code for Nurses also places
"responsibility and accountability for individual nursing judgments and actions" on the
nurse (Beauchamp 1994, 47). There is a similar statement in the physical therapists'
ethical code. Both professions clearly state that the individual health care provider
assumes an ethical responsibility for the individual's actions. It is also obvious from
malpractice insurance coverage and litigation that has occurred, that both nurses and
physical therapists are legally held responsible for their actions, regardless of the
physician's "order."

Education
The types of health care decisions have become more critical requiring more independent use of judgment by nurses and physical therapists. Due to the changing nature of health care, the level of education required to provide patient care by physical therapists and nurses has increased over the last several decades. Like nursing education, physical therapy educational institutions also expanded their programs to provide the level of education commensurate with the more advanced level of care provided clinically by physical therapists. Since the 1970's, schools of physical therapy have grown from one year programs following three years of college to an additional three or four years, with the Master's degree now being the standard. It is now possible to earn a doctorate in both physical therapy and nursing. Both of these fields have established specialty areas for which post-degree testing is required.

Medicine, nursing, and physical therapy entail specialized technical and scientific knowledge, and each of these professions have ethical and legal responsibilities to the patient. Each profession is clearly distinct, with specific roles and obligations for patient care, that is, they are neither equal nor ethically subjugated one to another. Therefore, the medical profession's claim to primary authority over the patient, based on its scientific and technical background, is no longer a reliable source for its claim to hierarchical superiority. While the professions of nursing and physical therapy have sought legislative means to allow their practices to be less controlled by medicine, neither have been successful in achieving their established goals\textsuperscript{11}. 
Socio-economic levels

The differences in socio-economic levels between physicians and other health care providers is another factor in the development and continuation of the hierarchical arrangement of health care\textsuperscript{12}. Because physicians have higher incomes and enjoy many privileges that keep them separated as a group, especially in hospitals where they are often provided designated areas reserved solely for physicians, they are able to exert control over "both the market...and organizational hierarchies" (Starr 1982, 21). Until recently, the economic power of the medical profession had a great influence on the entire health care industry, especially since hospitals historically were dependent on physician referrals. According to Engelhardt, physicians were able to practice more independently than other health care providers due to their higher economic status (1985, 69). As the physician's position of authority became accepted by society, it also became an established part of the structure of the health care institution. With the advent of managed care, hospitals are not as economically dependent on the referral of the physician, yet the hierarchical arrangement among health care providers has changed little.

Gender

Gender is another structural element that plays a significant role in health care relationships. While women in some parts of the country are beginning to achieve parity in medical school admissions, the majority of positions of authority and leadership continue to be in the hands of men because so few women previously had the
opportunities to become physicians or to rise within the hierarchical institutions. That relatively few sociological studies have been done on nonphysician health care provider groups is indicative of the extent of the authority that physicians and their concerns have held. In a 1989 study on medical practice, sociologist Renee Fox found that there were over one million nurses practicing in the United States while there were half as many physicians (1989, 74). Even though physicians are the minority among health care providers, social scientists tend to focus their studies on physicians and disregard other health professions (Fox 1989, 74). Many of the nonphysician groups, such as nursing and physical therapy, are dominated by women, and their distinct issues have not been as thoroughly studied as those of physicians and medical students. This is further evidence of the powerful and dominant position that the medical profession retains. Because of the historical devaluation of women, gender issues may be a factor in the reason why the concerns of the professions of nursing and physical therapy have not received the same ethical analysis that medicine has.

Since approximately 80% of health care workers are women and the majority of health care consumers are women, gender issues and their effects on the delivery of patient care need to be addressed (Sherwin 1992, 228). I am concerned that the gender division in health care due to the medical profession continuing to be mostly male, and its relationship to authority allows issues pertinent to women to be overlooked or misunderstood. Because the roles in health care have been so well accepted by society, gender can become invisible and the practices in health care that establish positions of
authority are accepted without question\textsuperscript{15}. Gender stereotypes in health care continue to be promoted as society has become accustomed to referring to physicians in the masculine and nurses in the feminine. While feminists have worked to change many societal patterns that traditionally placed women in inferior positions, women in health care continue to dominate the roles that have relegated them to lower status and lower-paying jobs. The invisibility of gender is reflected in the lack of study of how health care hierarchical arrangements affect those in less powerful positions.

The hierarchical arrangement among health care providers historically has been tacitly accepted by both providers and patients. The problem with hierarchies is that they separate things, persons, entities, or ideas into ranks of superior and inferior. When one entity is considered superior and placed above others, there is a resulting denigration of value of whoever or whatever is in the inferior position. Societal inequalities, such as are seen with race and gender are reflected in hierarchies among health care providers. For example, physicians who are usually white and male dominate the positions at the top of the institutional hierarchy just as they do in the business environment. While medical schools no longer overtly discriminate against women in their admission policies, gender continues to be an issue in specialty selection and promotion. Women may be discouraged from certain areas, such as surgery, and the paucity of women in the highest ranks of clinical administration is evidence of ongoing inequality at that level. As physicians remain in the higher hierarchical positions, women and minorities are then systematically valued less.
The health care environment has developed so that gender stereotypes continue with little notice. They have become woven into the practices and relationships among health care workers. Female health care providers traditionally have been those who provide the hands-on care to the patients and the male physicians have traditionally been the ones making the decisions and in positions of authority. These stereotypes continue to be witnessed in hospitals and are reinforced by the "doctor-nurse game." The object of this game as described by Leonard Stein is for the nurse "to be bold, have initiative, and be responsible for making significant recommendations, while at the same time she must appear passive" (1967, 699). This "game" is a common scenario in which a nurse makes a recommendation about patient care in such a way that the suggestion appears not to be affecting the physician's decision. The physician can then give the "order" for the same care that had been quietly recommended without seeming to have accepted the nurse's suggestions (Jameton 1984, 44 and Aroskar 1985, 52). By participating in this ongoing "game," nurses cooperate in maintaining their own invisibility. When physicians do not openly acknowledge the nurse's role in the decision-making aspects of patient care, it negatively affects the relationship not only between nurses and physicians but also between nurses and patients. The patients in these situations never realize that it is the nurse's judgment and recommendation upon which the treatment decision is based. While this scenario does not only occur between female nurses and male physicians, there is a likely gender component to this practice due to the gender distribution in the professions. While a nurse may use this technique out of concern for obtaining necessary care for a patient, it also may cause the nurse to feel resentment and loss of autonomy,
thus affecting the ongoing relationships between the nurse and physician.

The elements of authority, education, socio-economic background, and gender each affect how health professionals relate to each other. In order to address the ethical concerns of interprofessional relationships, it is first important to recognize the differences and similarities in the backgrounds of physicians, nurses, and physical therapists. These elements will affect how caregivers respond to each other and to patients. These structural elements that have been accepted in health care for decades, need to be considered as important elements in the health care environment with regards to their effects on patient care. The ethical issues involving these relationships and the ineffectiveness of principlism and casuistry in addressing them will be discussed later in this chapter. Further, Irigaray’s work on sexual difference will later be used as a model for allowing differences to be used constructively, especially in relationships.

Dynamic Elements of Relationships

Multiple levels and roles of practitioners

While the structural elements of health care relationships have been described as those factors that are relatively stable, there are also dynamic elements that may change in response to outside influences. Relationships in health care are affected by constantly changing situations that involve patients being admitted and discharged, fluctuations occurring in patients’ status, and patients being provided care by multiple health care professionals16. There are many variables that affect interprofessional relationships,
including the various roles and levels of competence of the individual health care providers. For example, there are several levels of nurse training, ranging from "nurse practitioners and registered nurses to licensed practical nurses and various nurse auxiliaries," (Engelhardt 1985, 64-65). These multiple levels are sometimes misunderstood by patients and may make communication difficult among health care providers. There are also licensed physical therapists, licensed physical therapist assistants, and on-the-job trained aides who may interact with patients and other health care providers. Further, there are physicians who have various specialties, residents, and medical students whose presence in hospitals affects the way health care providers relate to each other. In all of these groups there are those individuals who may be considered incompetent or inappropriate in their care of patients and relationships with others. Conversely, there are those health care providers who are constantly sought out by others because they have reputations for being excellent clinicians or caring individuals. Therefore, there are many variables in the personalities, behaviors, and levels of competence of the individuals that may enhance or hinder the development of interprofessional relationships.

Level of intimacy

Another dynamic element of interprofessional relationships is the level of intimacy that may be developed between persons. Health care is a unique segment of society in which relationships are developed among strangers but acquire an intimate appearance based on the type of care provided. Since relationships among nurses, physicians, and physical
therapists revolve around the sick and vulnerable patient, they are brought together in an arena that is necessarily intimate in providing care for those in need. However, interprofessional relationships also may be superficial and more like those among strangers. Therefore, as described in the previous chapter with regard to the patient/provider relationship, the unique relationships among physicians, nurses, and physical therapists fall on a continuum between intimate and stranger and need to be addressed as a hybrid of the two.

As previously discussed, relationships between patients and health care providers usually begin as strangers to each other and develop rapidly after the initial encounter. Interprofessional relationships develop within an environment in which the patient should be the center of attention, and therefore the level of intimacy that is established between the patient and provider is a major component of the health care environment. Having the patient as the ultimate focus of health care providers increases the level of intimacy between caregivers because providers not only have access to personal information about patients but also share in patients’ decisions and life-altering situations involving illness. Since the patient is the center of attention, the people who care for and about a patient often share an emotional connection. Sometimes health care providers are brought closer together emotionally by a particularly disturbing situation, or by a difficult or likeable patient. The amount of time that health care providers interact with each other varies considerably. Some health care providers, such as nurses, spend many hours together on a daily basis, and some, for example physicians, interact only intermittently. Often
personal aspects of one's life may be shared, such as when there is illness or death in the family. Other people choose not to reveal personal aspects of their lives. Just as the patient/provider relationship falls on a continuum between intimate and stranger, so do interprofessional relationships. Some health care providers remain strangers to each other even when working closely together; only exchanging patient-related information. Some relationships become truly intimate and deep friendships are developed, and occasionally marriages between health care providers take place. This dynamic element of interprofessional relationships will enter into the later discussion of the ethical issues among health care providers.

Public/private element

There is another element in health care relationships that seems to combine the structural element of gender and the dynamic element of the stranger/intimate continuum. Health care is unique in that it is a private service provided to patients in a public setting. Similar to the element of intimacy, the overlap of private and public occurs because patients are willing to provide personal and private access to their bodies and information while being cared for in a public institution in which this information is shared among persons unfamiliar to the patient. This distinction between public and private affects not only the patient/provider relationship, but also the relationships among health care providers.

As I have already described, the historical roots of nursing patient care are in the home,
and therefore they have been associated with the private domain of family and relationships. This can be contrasted with the public roles traditionally filled by men whose voices and experiences have described history for centuries\textsuperscript{17}. Further, since the public sphere is also the political arena, men have also controlled how institutions function and have established the traditional practice patterns (Gould 1983, 7). Because the male perspective has historically placed a greater value on the public arena, according to Alison Jaggar, there has been a "philosophical devaluation of the domestic realm" (1991, 81-82). This translates to health care issues because the traditional roles of women in health care involve performing hands-on care to patients that could be considered part of the private domain. Although 90% of the hands-on patient care is provided by females, positions of authority and power are filled by males (Holmes and Purdy 1992, 3). Due partly to their historical development as well as their specific patient-care functions, nursing and other groups, such as physical therapists, have been associated with functions normally performed in the home. Because of this division, nursing and physical therapy roles have become associated with the private arena and medicine with a more public arena. Since there has been a historically higher value placed on the public domain, it continues to be difficult to identify and place issues of a private realm in a central position of debate. This may partially account for the emphasis on the ethical nature of the physician/patient relationship with less discussion of ethical concerns regarding other health care professionals.

I will discuss in this chapter how principlism and casuistry have not adequately addressed issues relating to interprofessional relationships and the role of these structural and
dynamic elements. Luce Irigaray's work will provide some insight in understanding how masculine discourse based on indifference could reinforce this generalized and public discourse as the dominant voice in society. In the final chapter, I will discuss how her work on sexual difference can help uncover the value of feminine discourse and how that would affect the relationships among health care providers. Further, in the final chapter I will relate how gendered discourse and interprofessional relationships affect the care of the patient.

Principlism and Casuistry

The study of health care ethics has evolved since the 1960's with a progressive emphasis on making ethics more practical and useful in the clinical setting. Two of the major ethical approaches to decision-making in health care have been principlism and casuistry. In this section I will describe each of these frameworks for ethical analysis and discuss why they have been inadequate in addressing the ethical ramifications of health care interprofessional relationships. This discussion should provide a foundation for my later argument that interprofessional relationships should be studied not only by using principles and case studies, in addition to a consideration of obligations and care, but with special attention to the role of difference as described by Irigaray.

Description of Principlism and the Derivation of the Principles

As ethicists have become more involved in clinical decision-making, principles have become part of the vocabulary that is used by both ethicists and clinicians. Principlism,
or "the use of moral principles to address issues and resolve case quandaries," became the predominant methodology used in early bioethical deliberations. It was important in "providing a language for biomedical ethics, fostering its development, successfully grappling with perplexing issues and formulating public policy, and improving patient care" (DuBose, Hamel, and O'Connell 1994, 2). Principlism provided a means of communication between theory and practical dilemmas, thus becoming an important bridge between the didactic study of ethics and the clinic. With technology constantly increasing the ability of medicine to extend life, which resulted in the development of new ethical dilemmas, principlism provided a means for especially physicians to be able to discuss ethical issues among themselves and with philosophers. Principlism became a mechanism to apply philosophical considerations to clinical issues.

My intent is to discuss the methodology of principlism and not to critique the merits of the individual principles, which Beauchamp and Childress divide into four "clusters" of respect for autonomy, nonmaleficence, beneficence, and justice. While these principles have merit in moral reasoning, it is their derivation, interpretation, and application, not their content, that is of most significance to my argument. In fact, feminists have often found the principles of beneficence, autonomy, and justice useful in ethical deliberations. These are of significant importance to women who have suffered injustice, and who have been denied a right of self-determination\(^\text{18}\). These health care principles should be a component of the ethical discussions involving health care professional relationships. My argument does not imply that principles cannot be used appropriately, but that the
traditional manner in which they have been derived, interpreted, and applied makes them insufficient for addressing the ethical concerns that involve relationships.

In the fourth edition of their Principles of Biomedical Ethics, Beauchamp and Childress have expanded both the definition and the description of principlism in response to previous criticisms. They explain that principles should be considered as prima facie, with guidelines that can be revised so that ethical analysis is "principle-guided, not principle-driven" (1994, 5). They do not argue that principles should be used absolutely or in isolation. Shortly I will describe how they have incorporated specification and balancing into principlism to try to enhance its efficacy. Beauchamp and Childress explain that the principles used in health care ethics are derived from the common morality and use Rawls' method of "reflective equilibrium" to describe how principles are constructed within a historical community that includes social practices, institutions, and laws (1994, 100). Therefore, principlism as described by Beauchamp and Childress is responsive to the environment in which an ethical dilemma is posed. By using a process of reflective equilibrium, principles are derived from the common morality, and then are specified and balanced as the circumstances of cases interact with them. After describing how Beauchamp and Childress incorporate specification and balancing into the use of the four health care principles derived from common morality, I will discuss my concerns about the interpretation of principles. This critique will involve how principles have been interpreted by persons in positions of authority who have traditionally been male, and how certain ethical issues, specifically those relevant
to women, have been overlooked.

While early critics accused principlism of having a propensity to be used in an absolute manner, Beauchamp and Childress now argue that principles are "general guides that leave considerable room for judgment in specific cases and that provide substantive guidance for the development of more detailed rules and policies" (1994, 38). By making principles more specific, Beauchamp and Childress move from a general theoretical level to the more particular aspects of decision-making, thus making principlism more reflective of the concrete concerns that arise in daily moral decisions. Because Beauchamp and Childress recognize that the circumstances of ethical situations should be considered in ethical analysis, they emphasize the use of "specification" and "balancing" when applying principlism in decision-making.

Beauchamp and Childress define specification as a process in which principles are "developed conceptually" and then "sufficient content" is added to move "from general levels of theory to particular rules, judgments, and policies that are in close proximity to everyday decisions in the moral life" (1994, 28-31). Specification is particularly necessary when two persons claim to be invoking the same principle but arrive at different conclusions concerning an ethical dilemma. This can occur in health care when two health care providers believe that they are both adhering to a principle of beneficence with a patient, but they arrive at conflicting judgments. For example, a physician may examine a patient with AIDS and determine that the person would benefit by being
exercised and mobilized, and therefore the physician writes a referral for a physical therapist to work with the patient. When the therapist examines the patient later in the day, perhaps after the patient has received some medications with severe side-effects, the physical therapist may decide that the patient is too weak, disoriented, and debilitated to receive therapy at that time. Both caregivers invoke the principle of beneficence in their recommendations of treatment and believe that they are helping the patient, but their decisions conflict. To specify the principle of beneficence, the patient’s situation and desires would be considered, as well as any pertinent institutional guidelines on the care of patients. Further, a nurse’s assessment, possibilities for a compromise, and the existence of a previous conflict between the caregivers could be additional circumstances that should be considered in specifying how the principle of beneficence could be utilized. The specific circumstances surrounding the dilemma will help clarify the use of the principle of beneficence so that the eventual decision will be to the benefit of the patient.

While principlism is enhanced by specification, there remain potential problems associated with principlism. Beauchamp and Childress admit that specification "does not itself preclude the use of dogmatic, biased, arbitrary, or irrational views" from being expressed (1994, 31). I will argue that how the circumstances of situations are selected for consideration and how they are interpreted may influence the outcome of the decision-making analysis. Selecting and interpreting the circumstances of an ethical case are affected by issues of authority and gender that I will later address. I will discuss how
women’s voices traditionally have not been heard in health care and how this issue has not been addressed by principlism. Luce Irigaray’s work on masculine and feminine discourse will help uncover some of the problems related to these concerns.

According to Beauchamp and Childress, balancing is used when principles are in conflict and entails "deliberation and judgment about the relative weights of norms" (1994, 32). When ethical dilemmas arise, often two principles can be cited as pertinent but conflicting. Beauchamp and Childress use a method of balancing in these situations in which they attempt to "locate the ‘greatest balance’ of right over wrong" (1994, 33). Balancing is a process whereby certain considerations regarding principles are chosen to be included and perhaps are emphasized in the decision-making process while other aspects of the case are not considered. While they list certain conditions to "guard against arbitrary, purely intuitive judgments" (1994, 34), it would be impossible to prevent principles from being balanced subjectively. For example, the conditions that they list to help make balancing less arbitrary include the following: 1) the consideration of better reasons for overriding a norm, 2) considering the "realistic prospect of achievement" of the objective, 3) considering "alternative actions," 4) judging that the action or policy involves the "least possible" infringement of the norm, and 5) that there are minimal "negative effects" (1994, 34). Although these conditions are offered as ways of limiting the involvement of intuition, there are subjective judgments to be made when applying any of these conditions in balancing principles. The determination of what is considered in the balancing process is an important aspect when choosing a principle to
be applied in a specific situation.

The case described as an example in specification can also be used with regards to balancing. The physical therapist may recognize that beneficence, that is, trying to help rehabilitate the patient, and nonmaleficence, or not wanting to cause the patient more harm, are in conflict when trying to decide whether to treat the AIDS patient. The physician appears to believe that beneficence entails treating the patient. When the physical therapist uses balancing to decide between the two principles, the conditions noted above could be applied. For example, there could be reasons for nonmaleficence to override beneficence in this case if the patient's wishes are considered, if there is not a likely positive outcome by performing a treatment, if the requested treatment is not the least form of infringement on the patient, or if the therapist is seeking to minimize the negative effects of a treatment to the patient. If the physical therapist decides that nonmaleficence overrides beneficence, therefore deciding not to perform the treatment, the therapist must also balance obligations to the patient and to the physician. The physical therapist may believe that the professional relationship with the physician may be damaged if the physician's "orders" are not carried out. Balancing and specification do not adequately address this additional aspect of the nature of interprofessional relationships. These techniques do not provide assistance in applying principles when the interpretation of the principle is in question. These differences of interpretation may be related to the perceived obligations that the physician and the physical therapist have toward the patient. Further, these principles may not be interpreted and applied the same
by persons with different authority and gender. These limitations of principlism and casuistry will be discussed later in this chapter after the description of casuistry.

**Description of Casuistry**

Before continuing a critique of principlism, I shall turn to the role of casuistry in health care. First I will present a brief history of the renewal of casuistry in health care ethics and how it has attained a position of significance in health care ethical deliberations. Then I will describe certain similarities between principlism and casuistry and how they both can be critiqued from a feminist perspective.

At about the same time that principlism became prominent in health care ethics, casuistry also began a revival. According to Albert Jonsen, during the 1960’s there generally was a greater interest in the "perplexities of actual personal, institutional and social life," which he claimed related to a renewed interest in casuistry (1991, 296). The use of casuistry in ethical decision-making has helped reveal the importance of emphasizing individual circumstances in ethical considerations when using case studies. Although the history of casuistry includes its fall into disrepute, Jonsen and Toulmin have helped revive interest in its use in ethical analysis and claim that casuistry is "indispensable."

Casuistry had been widely used by Roman Catholic Jesuits during the early Middle Ages. However, in the mid-seventeenth century, Blaise Pascal’s attack on the Jesuits in his *Provincial Letters* led to casuistry falling into disrepute. Pascal criticized casuistry
because it had become corrupted. He claimed that it not only was partial toward the rich, but that the entire casuistical method was no longer valid because of the widespread misuse and dishonesty of those using casuistical reasoning (Jonsen and Toulmin 1988, 11, 15). The result, according to John Arras, is that casuistry can still "conjure[s] up pejorative images of disingenuous argument and moral laxity" (1991, 30). Jonsen and Toulmin’s work has served to help redefine and reinstate the positive aspects of casuistry in moral reasoning. Their work has been instrumental in helping identify and define the role that casuistry plays in health care ethical decision-making.

Jonsen and Toulmin define casuistry in The Abuse of Casuistry as:

[T]he interpretation of moral issues, using procedures of reasoning based on paradigms and analogies, leading to the formulation of expert opinion about the existence and stringency of particular moral obligations, framed in terms of rules or maxims that are general but not universal or invariable, since they hold good with certainty only in the typical conditions of the agent and circumstances of action (1988, 297).

Casuistry emphasizes the process of reasoning by focusing on how the practical circumstances of particular cases interact from an ethical standpoint. Case interpretation is used with priority being given to analogical reasoning, so that "moral knowledge develops incrementally through the analysis of concrete cases" (Arras 1991, 29, 31).
The circumstances of the cases themselves, rather than moral theory, provide the groundwork for analysis. There is limited appeal to principles or maxims, and when they are considered, it is in conjunction with specific circumstances of the situation. Although Toulmin does not emphasize the role of principles in casuistry, he acknowledges that there is a limited place for them, if they are utilized with discernment and in relation to the specific case with consideration of individual differences.

Comparison of Principilism and Casuistry

In order to effectively compare principilism and casuistry, it is necessary to distinguish between two types of casuistry. A weaker version of casuistry is one in which already-existing or independent principles or moral maxims are applied to various cases, as cases are compared one with another. Arras describes a stronger version of casuistry in which principles are derived from specific cases. In the stronger type, principles become "summaries of meanings already embedded in our actual practices" (Arras 1991, 30-34). While both versions place a priority on the role of the particular cases, they both also include the use of principles or moral maxims in the case deliberations.

The weak version of casuistry can be compared more directly to principilism because in it principles are delineated prior to being applied to cases. Some of the same criticisms that will be discussed in reference to principilism that address the derivation, interpretation, and application of the principles can be directed to this form of casuistry. In addition to criticisms specifically involving the principles, there are additional
interpretive concerns with casuistry. While casuistry emphasizes the circumstances and texture of cases, there is still concern over which circumstances are considered and how they are interpreted. In health care case presentations, there can be many variations in how the circumstances of cases are presented or how medical information is interpreted. For example, casuistry could be used in the case in which the physician and physical therapist disagree over whether treatment for an AIDS patient is appropriate. It will be assumed that the patient’s mental status made it impossible for communication of the patient’s desires to the health care providers. Specific circumstances of the case would be selected by the physician and physical therapist for discussion. In any ethical dilemma, the selection of information and circumstances to consider will affect the ultimate decision, and therefore who decides what to consider and how to interpret that information is of critical importance.

Another limitation of applying principles to cases as in the weaker version of casuistry, is that by beginning with a set of principles in mind, boundaries may inadvertently be placed on the interpretation of the case. If the physician believes that the principle of beneficence should be considered primary and that there is an obligation to do whatever is deemed to help the patient, then emphasis may be placed on the circumstances of the case that relate to the patient’s growing weakness from being in bed, thus leading to a decision that would involve treating the patient. On the other hand, if the principle of nonmaleficence was considered foremost, the information relating to the patient’s acute state of nausea or discomfort may be emphasized so that it will appear morally correct
to forgo the treatment.

In the stronger version of casuistry, in which principles are derived from cases, there is also a concern about how the case is presented. What circumstances of the case are chosen for consideration could affect the derivation of the principles. In the example above, I have shown how the significance of the selection of circumstances and their relevance to a case might affect the treatment decision. By emphasizing different circumstances, there could be disagreements over which particular principles might be considered important in a given case. Since in this stronger version of casuistry, the principles are derived from the specific case, the choice of circumstances could be determinative of the principles used in deciding the outcome of the case. As with principlism, these disagreements could be related to issues of gender or authority.

Beauchamp’s and Childress’ description of principlism resonates with elements of both types of casuistry regarding how the principles can be applied to cases or derived from the circumstances of cases. They propose that neither principlism nor casuistry are static or absolute, but that they have the capability of responding to specific situations. The role of principles in casuistry and in principlism may be similar, but the two methodologies differ in the emphasis placed on principles and how cases are used. Casuistry focuses more on an analogical reasoning between cases with the common aspects of the cases being more important than the principles themselves. Although casuistry focuses on particular cases, principles are used in the process of moral
reasoning, either when applied to cases or derived from cases. Beauchamp’s and
Childress’ latest explanation of principlism incorporates the circumstances of situations
as mediating factors in principlism through the processes of specification and balancing.
The more recent versions of both principlism and casuistry include responses to
criticisms that help strengthen them. Jonsen and Toulmin now find a broader role for
principles in casuistry. Both of these methodologies are moving toward each other and
away from the extreme realms of absolutism and relativism for which they were once
accused.

**Inadequacies of Principlism and Casuistry**

*for Use with Relationships*

During the last two decades principlism and casuistry have been used appropriately to
mitigate many health care dilemmas involving crisis situations. However, these
methodologies are limited in their ability to respond to ongoing issues involving how
health care professionals relate to each other. Most of the criticisms that I will discuss
regarding the insufficiency of principlism and casuistry in addressing the ethical issues
related to interprofessional relationships will apply to both methodologies. These
limitations stem from the derivation and interpretation of the principles themselves as
well as the application of principlism and casuistry in specific cases. Issues of gender
and authority that have been shown to play a significant role in interprofessional
relationships are major reasons why principlism and casuistry are not sufficient in
addressing ethical concerns that arise between caregivers.
Interpretation of Principles

While health care principles historically have been used to analyze critical dilemmas including issues related to patients' rights (autonomy), obligations of providers (beneficence), end of life decisions (nonmaleficence), and resource allocation (justice), I will argue that they are not sufficient to address ethical issues that arise in interprofessional relationships. One of the primary limitations of principlism is the narrow way in which the principles have been interpreted and specified. Because there is a wide variability among situations that occur in health care due to patient and provider differences, a narrow interpretation of the traditional health care principles cannot address the types of issues that involve numerous structural and dynamic elements of interprofessional relationships. I will argue that some ethical concerns involving interprofessional relationships have been overlooked or not thoroughly investigated because of this narrow interpretation and the way that the principles have been applied. How gender and authority play a role in this inadequate examination of interprofessional relationships will be described.

The narrow interpretation of principles

I will use the principle of beneficence as an example of how its traditional narrow interpretation has affected the provision of health care. In the previous chapter I described how Beauchamp and Childress described beneficence as being derived from the role obligations of physicians. I argued that the roles of nonphysician caregivers also give rise to obligations of beneficence to patients. The problem remains, however, that
the principle of beneficence historically has been described in terms of a male-dominated profession. I have shown how other nonphysician professions have evolved over the last two decades and now practice using more independent judgment and with greater obligations to patients. Because the roles of health care providers have changed, the traditional interpretation of the principle of beneficence no longer sufficiently describes the current health care environment. The principle of beneficence can no longer narrowly be interpreted as addressing primarily the medical profession, but now must be broadened to include all health care providers who interact significantly with patients.

The traditional interpretation of the principle of beneficence with the focus on the physician gives rise to problems between health care practitioners. If we consider the previous case of the disagreement between the physician and the physical therapist over the appropriate care of the AIDS patient, the interpretation of the principle of beneficence could be an issue. Because physicians traditionally have been considered as the caregiver with the obligation of beneficence to the patient, a decision about the care of the patient could be determined as that which the physician deems appropriate without considering the voices of other providers. If the principle of beneficence were more broadly interpreted to reflect the current practice of health care, patient care would be affected because it would be understood that physical therapists and nurses also have obligations of beneficence to patients. I will argue that their concerns about the well-being of the patient ought to be considered in an ethical decision-making process. However, even though it may positively affect patient care, broadening the interpretation of the principle
does not solve all of the interprofessional ethical concerns. Therefore, merely reinterpreting the principle of beneficence will not make principlism sufficient for analyzing these issues. There are other aspects of principlism and casuistry with ethical ramifications regarding relationships that need to be considered. The problems with how principles are applied and how cases are chosen will be discussed in reference to relationships.

The interpretation of principles, using specification and balancing, not only can affect decisions relating directly to patient care, but also can affect interprofessional relationships. I will argue that patient care and interprofessional relationships are not separate instances in health care, but that they intertwine. The following case is an example of how the interpretation of a principle can affect a health care relationship. In this case the care that a patient receives may be affected when an interprofessional relationship becomes a part of the decision-making process. Consider a case in which an experienced nurse knows from having provided individual care for a particular patient over many hours, that a physician’s order for a certain medication will be detrimental to the patient. How the nurse chooses to proceed is an example of a common ethical decision. The nurse must choose an appropriate action from among several options that have various consequences associated with the decision. One of the choices is to call the physician and express concern about the prescribed medication, but it is known on the nursing unit that this physician wants the orders carried out as written without discussion. Previous telephone calls to this physician have been threatening and abusive. Another
decision option is not to give the medication to the patient based on the nurse’s judgment with the consequences being a possibly irate physician and possible administrative sanction later. Another consideration that could influence the nurse’s decision would involve the obligations owed the patient. The nurse may recognize that the principle of beneficence requires patient care be provided solely to benefit the patient.

However, if the nurse resorts to a traditional and narrow interpretation of the principle of beneficence, the nurse could decide that the physician has a greater obligation of beneficence to the patient, and the medication would be given without questioning the authority of the physician. If the nurse had interpreted beneficence as equally applying to the role of the nurse in patient care as to the physician’s role, the nurse probably would have made a decision to protect the patient’s well-being. The nurse’s decision could have been influenced by a previously established authoritative relationship with a physician that could affect how the nurse interprets her obligation of beneficence to the patient. The interprofessional relationship may become an aspect in the nurse’s deliberation of choices. If the previously established relationship was based solely on the physician’s authority, and this became the basis for the decision, patient care may suffer because the nurse could decide protecting the patient is secondary to the authority of the physician.

As this case illustrates, interprofessional relationships can include factors that may affect how principles are interpreted and how decisions are made. I will discuss how gender
and authority are a part of how health care providers relate to each other. While there may be other important components, I have chosen to focus on these factors because they are such an integral part of interprofessional relationships. I will argue that principlism and casuistry are not sufficient in addressing the ethical ramifications of gender and authority with regard to these relationships. After examining the limitations of principlism and casuistry for mediating conflicts that arise from issues of gender and authority in interprofessional relationships, I will discuss in the final chapter how these relationships could be more thoroughly analyzed with Irigaray’s work on sexual difference and how it is reflected in discourse.

**Gender and the interpretation of principles**

Although most early moral reasoning was studied and described by male philosophers who promoted a more detached principlistic method of moral reasoning, Beauchamp and Childress have tried to correct this by emphasizing the importance of circumstances in principlism. However, since gender bias continues to be embedded in our social practices, and health care continues to be divided by roles in which gender is apparent, it is important to examine how the interpretation of principles has been influenced by gender. There are ethical concerns involved in the relationships between the majority of female nonphysician health care providers and the male-dominated medical profession that have not been thoroughly addressed.

Principlism is subject to some of the same problems regarding gender bias that affect
society at large. Just as language historically has been controlled and interpreted through a male perspective, the health care principles also have been affected by this limited perspective. Gender bias in language is difficult to detect because its existence is often denied. If there is a presumption that language is not gendered, then a destructive bias becomes invisible, subtle, and pervasive. The pervasiveness and acceptance of male-determined language has become unconscious, and therefore even more difficult to identify and change. Although gender-neutral theories have been presented as "genuinely universal," society, culture, and morality continue to be interpreted through masculine descriptions and male moral voices (Sherwin 1992, 2). While many feminists have discussed the gendered nature of language, Irigaray’s method of mimesis, which will be explained in the next chapter, provides a means for recognizing how insidious a masculine discourse is in society. Health care provides a good example of how gender inequalities remain unquestioned by society in general. While the number of women who are being accepted into medical school is reaching parity with the population, physicians continue to be referred to with the masculine pronoun as if the male gender is the universal standard. Health care professions remain segregated by gender\textsuperscript{20}. Therefore, since there is a probability of a male bias in health care, specifically in the presentation of the health care principles, we must question the use and interpretation of principles to an even greater extent. I will address this concern later when the application of principles is discussed.

Luce Irigaray’s work on masculine and feminine discourse will be used to explain the
pervasiveness of masculine discourse. By analyzing how the principles have been described and interpreted using Irigarayan techniques that will be described in the next chapter, I will show how masculine language has affected the practice of health care. Using her work, I will discuss how the physician has been considered the universal subject and how all other health care providers have been marginalized. Irigaray’s critique of the description of woman as the mirror of man has significance for the relationships among health care providers. Describing moral experience from the perspective of only one group reduces the significance of experiences that might be differently encountered by another group. Although the majority of health care services are provided by women, their voices have not been clearly heard in ethical discussions.

**Authority and the interpretation of principles**

Since the health care environment traditionally has been hierarchically arranged, issues of authority arise during decision-making. As I described earlier, the historical development of medicine, nursing, and physical therapy has contributed to the hierarchical and authoritative environment of health care. The interpretation of principles is also affected by this issue of authority between caregivers, especially as it relates to two providers who might interpret principles differently. The issue is raised as to who has the authority to make the ultimate decision. Principlism as described by Beauchamp and Childress has not addressed these ongoing problems that arise between health care providers.
One of the problems that can be attributed to Beauchamp’s and Childress’ description of principlism is their emphasis on the obligations of physicians without recognizing the obligations of other health care providers. I have already discussed how nurses and physical therapists have obligations to patients, yet a dilemma arises when there is a difference in the interpretation of a principle by a physician and another caregiver that would affect the care of the patient. Since the principle of beneficence has been derived from and specified by medical tradition, the practice of using medicine as the benchmark for the interpretation of principles is reflected in the traditional acceptance of the physician’s judgment claiming the position of superiority. This can be detrimental to patient care if the physician’s concern for beneficence is alone considered, without listening to the voices of others who also have obligations to the patient.

Principlism does not help answer the dilemma of who has the authority to make a decision when two interpretations of a principle clash. For example, a physician may invoke the principle of beneficence in a case involving a patient with a completely severed spinal cord. The physician could decide that it would be psychologically better to tell the patient that a full recovery may be possible, even though it would require not telling the truth. A dilemma arises if an experienced physical therapist, who works with the patient for hours each day, also claims that beneficence would require telling the patient the truth regarding the patient’s disability so that emotional and psychological healing could begin sooner. If the decision is made solely on the authority of the physician, it is possible that less than optimal care could be provided for a patient. If
the principle of beneficence is specified with incomplete or inaccurate information and is attributed to the "medical tradition" in which the physician's obligations traditionally have been primary, then its interpretation and use could be flawed.

I am not advocating that all health care providers are equal since there are wide variations in educational background, expertise, and level of risk. In health care there may be some limited appropriate purposes for there being a hierarchical system. Since there are so many different persons interacting with each patient, there is a need for someone to be in a leadership role to direct and coordinate the care of the patient. The physician has traditionally held this position and has assumed the responsibility for decision-making authority in conjunction with the patient. As health care has evolved and other health care providers have assumed more responsibility for the well-being of their patients, this authoritative relationship has not changed. As nonphysician caregivers recognize and accept their obligations to patients, their voices should also be part of the decision-making process.

In addition to affecting the quality of patient care, the influence of who has the authority to make decisions on the use of principles also affects interprofessional relationships. As in the example of the spinal cord injury patient above, when a physical therapist's and a physician's interpretation of beneficence differs and would result in different approaches to a patient, principlism does not assist in deciding which voice should be heard. The autonomy of the persons involved in this type of dilemma is affected. Both
persons believe that they have correctly interpreted what would be best for the patient, but only one decision will be implemented. If the basis of the derivation of the principle of beneficence is based solely on the obligations of physicians, then the physical therapist will suffer a loss of autonomy in the care of the patient. However, each health care provider’s obligations to patients are such that they each involve a level of autonomy in order to make critical decisions regarding patient care. Patient care decisions need to be made, but they should not be based on the assumption of the primacy of the physician’s authority. Principlism and casuistry have not addressed these intertwined issues of autonomy and authority. I will discuss in the final chapter the necessity of cooperation among health care providers in making difficult decisions in the unique environment of health care. Principlism has not provided a means to mediate when differing interpretations of principles occur, in fact, it may have contributed to the continuing persistence of the physician being considered to have the sole voice of authority in health care.

The issue of authority in health care is also related to gender since women traditionally have not held positions that have the authority to choose and interpret principles, nor have they been involved in selecting cases to be studied that might include interprofessional health care dilemmas. As previously discussed, although in health care institutions women provide the majority of hands-on care for patients, positions of authority are historically held by men. Because they are in intimate contact with patients and their families, health care providers, such as nurses and physical therapists often
assume the role of nurturer as well as decision-maker. Since nurturing roles historically have placed women in subordinate roles, they are at risk for their role of decision-maker becoming secondary\(^{22}\). Irigaray's work on sexual difference and multiplicity will be discussed in relation to roles being associated by gender. Because the health care principles have been narrowly interpreted and applied, they have not been used to address issues such as how authoritarian relationships in health care affect the participants.

**Application of Principles**

Many health care providers, in addition to physicians, are disturbed by ethical dilemmas encountered in the daily care of patients. Nursing and physical therapy are only two of the many groups of caregivers who are in close contact with patients and their families, and who often witness or may be involved in ethical dilemmas. I will argue that these "other" providers have a significant impact on the quality of care that patients receive and that they should be recognized for the closeness of the relationships that they develop with patients as well as their influence on patients' decision-making process. These are often the health care providers who spend the most amount of time with individual patients in hands-on care. They often obtain more specific information about a patient's life than the physician because they have more opportunity to interact with the patient.

When ethical decisions are made regarding a patient's care, often the physician's voice is the only one that is considered. Confining decision-making to one voice promotes the application of principles in cases without the necessary attention to the circumstances of
the patient's situation. Nurses and physical therapists are often able to obtain more specific information about a patient's life, such as personal, psychological, social, historical, and cultural factors that add meaning and texture to a case being studied. When principles are being applied to cases, the details of the particular case, including how the patient has been responding to current interventions, should be a part of the decision-making process. The patient's responses are observed by health care providers who interact with patients on a more intimate level and more often than physicians. Emphasis must be placed on the often changing situations of an ethical dilemma. To do so, the circle of ethical discussion must be broadened to include nonphysician health care professionals in addition to physicians. If ethical analysis of a case included a greater variety of voices, including those in close contact with a patient, different ethical decisions may be made. Unless an ethics committee is involved, the physician is usually the sole voice in the decision-making process with the patient, family, or surrogate. If interprofessional relationships were different, principles could be specified more completely with the inclusion of information obtained by those health care providers other than physicians.

To help principlism be clinically relevant and responsive to circumstances, Beauchamp and Childress describe specifying and balancing to make the application of the principles more specific to the situation. Although they state that "[i]f unacceptable content is discovered in formulations of principles...an attempt is made to find acceptable content" (1994, 104), they do not address who should designate and interpret what is
"acceptable." In order for principlism to be the type of ethical analysis that they have described, the principles must be applied in a careful manner. However, in the health care setting, ethical analysis cannot always proceed according to Beauchamp's and Childress' carefully outlined methodology. Principles may be applied without thorough attention to the details and circumstances of a situation based on who has the authority to be a part of the ethical deliberations.

For example, it is not uncommon for older patients to have multiple hospitalizations toward the end of life. Although a physician has the authority and responsibility for admitting the patient to the hospital, the same nurses and physical therapists often care for the patient on multiple admissions. As therapists work with patients trying to assist them to regain their highest possible functional ability, patients often express their concerns over their loss of independence, their becoming a burden on the family, their concerns about "lingering on," and their preparations for death. Patients also often speak freely about their family relationships. This type of information should be included during a discussion about whether to begin artificial nutrition on a patient, but is usually overlooked by those in authority. Although this lack of communication among health care providers may not indicate a limitation of principlism, it illustrates how only certain circumstances of a situation might be selected to be considered. If other health care providers were included in the deliberations regarding patient care, the scope of the circumstances selected for consideration could be expanded so that more valid decisions about patient care could be made. In order for this scenario to include more voices, the
basis for interprofessional relationships would need to be changed. This will be discussed in the final chapter.

The Problems Related to Choosing Cases

One of the reasons that ethical concerns involving interprofessional relationships have not received much attention is that those with the authority to identify and study ethical issues have not recognized the ethical implications of these relationships. Interprofessional relationships traditionally have been premised on an authoritative paradigm. They have remained unquestioned because they have been accepted as the norm and have not been considered problematic by those in positions of power. Those in the superior position in the hierarchy may believe that it is not in their interest to become involved in discussions that might question their authority.

If those in authority who have the power to choose cases for ethical analysis do not decide to study the ethical ramifications of interprofessional relationships, then principlism and casuistry cannot be fully engaged to address the ethical role of authority and gender in health care. Although how authority is wielded affects almost everyone involved in health care, those who are affected by authority the most, especially women, may be excluded from these ethical discussions. Further, their perspectives are often overlooked or trivialized. Those who are at the top of the hierarchies choose the issues to be studied and may be unable to discern that there are ethical concerns involving other health care provider groups (Addelson 1986, 306). It is a predicament for those in lower
positions of authority since they have not been in positions to bring forth ethical concerns regarding authority and gender in interprofessional relationships. Therefore, in the case above where the physician and the physical therapist disagree on whether to tell the spinal cord patient the truth about the patient's condition, the physician may not be aware that by claiming to have the authority to make the final decision that other health care providers' voices may be silenced. Issues arise relating not only to the role of the physical therapist, but also what the therapist's obligations of beneficence are to the patient. If the therapist's voice is not considered in the decision-making process, the result may be detrimental to the patient and the therapist. I will further discuss how these are related in the final chapter.

In addition to problems associated with the selection of cases to be studied, there are concerns about how a case is presented. What circumstances are chosen to present, by whom, to whom, and where the case is presented may influence the outcome. Issues of authority also enter into these decisions about the presentation of a case. The case regarding the disagreement between the physical therapist and the physician could be presented as a case study for ethical analysis. There would probably be different outcomes if it were presented to or by a group of physical therapists as opposed to a group of physicians. It would matter from whose perspective the case would be presented because each caregiver might consider different circumstances as pertinent to the case even if they present similar clinical information. If the case was presented to a group of physicians, issues of authority and control might be discussed, including the
physician's legal and ethical obligation to the patient. The physical therapists might emphasize the importance of focusing on the patient's rehabilitation potential and how all of the health care providers need to work as a team. Once again the issue of authority influences how principilsm and casuistry are used. This case illustrates how the limitations of principilism and casuistry affect ethical decisions that involve more than one health care provider.

Summary

Although the traditional ethical analyses of principilism and casuistry have been useful in some decision-making ethical processes, they have not sufficiently addressed the ongoing ethical questions derived from interprofessional relationships. While the health care principles are necessary components of ethical analysis, there are specific limitations to principilism and casuistry based on how principles have been interpreted and applied. I have shown how gender and authority affect interprofessional relationships and how patient care decisions can be involved.

One of the unique aspects of health care is the fact that many persons provide treatment for the same person. There is a definite element of interdependence among the providers and with the patient. No one health care provider can work alone to provide the necessary care for a hospitalized patient. Nurses, physicians, physical therapists, and many others work together to help patients return to as healthy a state as possible. Since caregivers do not work in isolation, they must interact with each other to provide optimal
care for patients. As I have already shown in the previous chapter, each health care provider is obligated at the minimum to provide competent care for patients. It has been my experience both as a provider and recipient of health care that caregivers must work together as a team to provide optimal care. I will return to the importance of interdependence among health care providers in the final chapter.

NOTES

Chapter Three

1. Interprofessional relationships are affected by the context of where and how health care is provided. Each health care facility has a different environment and philosophy regarding the interaction of health care providers. For example, there is a much different type of interprofessional relationship in hospitals where all health care providers share a cafeteria and can socialize over a meal, than in hospitals where a separate dining room for physicians is provided. There are other contextual factors, such as whether the facility is a teaching hospital, its profit status, if it has a religious affiliation, and its size, which may affect how professionals interact with each other.

2. There is a unique relationship of authoritative control between physicians and administrators that I will acknowledge but not address in this work since I am focusing on those who provide direct patient care.

3. When physicians decide that a specific treatment is necessary for a patient, they write "orders" in the medical record. The continued use of the word "order" reinforces the hierarchical status of physicians over other health care providers. When a request is made of a fellow physician, it is called a consultation or a referral, not an order for another physician to do.

4. There are several other reasons that medicine has been able to maintain its position of authority over other professions. In his book, Nursing Practice: The Ethical Issues, (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1984), Andrew Jameton notes that "medicine continues dominance over nursing through institutionalized gender discrimination and hospital bureaucracy" (42). While experience makes me believe that this statement is accurate, it would require a sociological study to deal with the institutional components involved in this issue.

5. Race and sexual orientation would also be considered structural elements.
6. For an indepth view of the history of medicine, see Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, Inc., Publishers, 1982). Starr explains that the "power of medicine" began with society's dependency on the physician's "knowledge and competence" which grew as physicians' power increased over "hospitalization, gatekeeping, and insurance" (19-20). Further, in No Longer Patient: Feminist Ethics and Health Care (Philadelphia: Temple University, 1992), Susan Sherwin attributes medicine's being accepted as the dominant provider of health care to its appeal to objective data and technology (147). One of the ways that medical education grew to be consistently science-based was due to the 1910 Flexner report which established basic science courses as requirements for all medical schools. This allowed physicians to claim that their knowledge was scientifically based.

7. Paul Starr explains that as physicians succeeded in establishing themselves as the medical authority in the clinical world, they also gained in cultural and social authority as well. They were able to give "definitions of reality and judgments of meaning and value." Social authority allowed them to give orders to others over whom they had "control of action" (1982, 13-14). They also were successful in gaining authority outside of their clinical expertise which allowed them to gain "social privilege, economic power, and political influence" (5).

8. There is much ambiguity and uncertainty in the care of patients due to the variability in patients and their responses to various disease processes. In Essays in Medical Sociology: Journeys into the Field (New York: John Wiley and Sons, 1979), Renee C. Fox states that medical students and young physicians have "difficulty in distinguishing between personal ignorance or ineptitude and the limitations of present medical knowledge" (20). As medical students progress through their medical education, they are encouraged to appear certain about their decisions, even as they are learning how inexact and ambiguous medicine can be (25). This is a particularly difficult dilemma because students want to provide superior care to patients based on their scientific knowledge and objective information that they were taught in school, but as they encounter more patients, they realize the significant level of ambiguity and uncertainty with which they are faced.

In The Silent World of Doctor and Patient (New York: The Free Press, 1984), Jay Katz notes that it is human nature to yearn for certainty over uncertainty so there is perhaps an innate drive to eliminate ambiguity. Further, many medical students are taught that they should not appear uncertain to patients, so that they can maintain their position of authority to make decisions and to seem infallible (174, 198).

In The Nature of Suffering and the Goals of Medicine (New York: Oxford University Press, 1991), Eric J. Cassell says that uncertainty is particularly "intolerable" to "the ill because their existence seems threatened" (75-76). He describes how physicians, especially as students, also feel threatened by the feeling of uncertainty because they fear "something untoward might happen to one of their patients" (76).
9. The control that society has granted the medical profession to determine the definition of "normal" as it relates to health further illustrates the level of authority of the medical profession throughout society. A relatively small group of people determine the norms upon which the rest of society rely to decide when they should seek health care.

10. Feminists, including Susan Sherwin, Virginia Warren, and Mary Fainsod Katzenstein, have recognized that the role of housekeeper places woman in a low hierarchical position. Their naming of certain types of health care concerns "housekeeping issues," such as arise from ongoing situations similar to interprofessional relationships, reflects how these issues have traditionally received little notice. This is an appropriate term for these issues since they involve many female health care workers and are often considered too mundane or insignificant to discuss, rather like the plight of the housewife.

11. These failed legislative attempts also demonstrate the political and societal control that medicine maintains. The American Medical Association and its political action committee have effectively been able to maintain political control of other health care groups. Legislatures have been slow to allow nurse specialists legal authority to use their skills fully, especially in areas of pediatrics and obstetrics. Physical therapists have also had limited success in gaining direct access to patient care through legislative means.

12. In No Longer Patient: Feminist Ethics and Health Care (Philadelphia: Temple University Press, 1992), Susan Sherwin claims that physicians's decisions are affected by their backgrounds and social status (231). For example, if a male physician from a higher socio-economic position gives advice to a patient, how that patient views the physician may influence whether the advice is followed.

In The Healer’s Power (New Haven: Yale University Press, 1992), Howard Brody describes that when the physician's "cultural power to define medical truth and knowledge" is combined with a power of a "higher socioeconomic and educational" class, others will defer to the physician's wishes (18).

13. There are other concerns associated with the gender division in health care. Since the majority of the medical profession is male, there is a strong probability that the norms of health will be viewed, even if unintentionally, from a male perspective. For example, the powerful medical institution continues to determine what health issues are to be studied, and women's health needs only recently have been addressed. By not including women in research studies for so long, the effects of certain interventions for women continue to be uncertain. Although the physiology of women differs from men, health care for women has traditionally been premised on factors specific to men. Medicine historically has overlooked the needs of the female as if she were invisible, nonexistent, or secondary. Traditional medical ethics has only recently begun to address these concerns of women. Little has been written about the detrimental nature of the hierarchical arrangement of health care, and when nurses have attempted to discuss the issue, it is often discounted as "whining." See Susan Sherwin, No Longer Patient.

14. According to Helen Bequaert Holmes and Laura M. Purdy, eds. Feminist Perspectives in Medical Ethics (Bloomington: Indiana University Press, 1992), while gender inequality is a concern in all aspects of our society, it is particularly problematic in health care in which the minority of white males continues to control not only the clinical aspect of health care, but also the determination of what ethical issues will be studied. They claim that traditional medical ethics has accepted the institution of medicine without critique (3). Susan Sherwin adds that medical ethics "has remained largely silent about the patriarchal practice of medicine" (23) in No Longer Patient: Feminist Ethics and Health Care (Philadelphia: Temple University Press, 1992). Since the majority of hands-on patient care is provided by female health care practitioners, more focus needs to be placed on the feminist perception of both clinical care and ethics in health care.

Until recently, "medical" ethics was taught to nurses and physical therapists using issues and cases more pertinent to physicians. Even in programs dominated by women, cases often focus on dilemmas that male physicians face. That is one of the reasons that I have chosen to use the terminology "health care ethics" as opposed to "medical ethics" or "bioethics." I propose that health care ethics is a more inclusive term than medical ethics and a more patient oriented term than bioethics. It also places "care" in the central position of the name which I believe is the appropriate place for care.

15. In "A Comment on Fry's 'The Role of Caring in a Theory of Nursing Ethics,'" in Feminist Perspectives in Medical Ethics eds. Helen Bequaert Holmes and Laura M. Purdy (Bloomington: Indiana University Press, 1992), pp. 107-112, Jeannine Ross Boyer and James Lindemann Nelson capture the scope of the problem of the invisibility of gender difficulties in the following statement: "If thoughtful scholars can miss the significance of gender differences when addressing a field as massively gender stratified as nursing, then the obscuring forces are powerful indeed" (107).


17. The division between public and private domains has been described as the generalized versus the concrete by Seyla Benhabib in Situating the Self: Gender, Community and Postmodernism in Contemporary Ethics (Cambridge: Polity Press, 1992). She claims that the generalized other is viewed as being similar to ourselves, and hence is "a rational being entitled to the same rights and duties." We would interact with this abstract concept of another person in the "public sphere of justice." Further, the concrete other is someone who is known by specific circumstances, a history, and an emotional component (163-164). If an interaction with a person occurs in the private domain, there is a greater possibility of knowing specific and concrete aspects of that person's life and being aware of the various relationships associated with that person.
18. In "A Feminist Critique of Biomedical Principism," in A Matter of Principles? Ferment in U.S. Bioethics eds. Edwin R. DuBose, Ronald P. Hamel, and Laurence J. O'Connell (Valley Forge: Trinity Press International, 1994), pp. 164-181, Christine Gudorf claims that the "only adequate bioethics is one that includes this simple principle: promotion of the common good includes the good of all persons in the community," which resonates with the principle of beneficence (168). Further, Patricia Ward Scalsas, in "Do Feminist Ethics Counter Feminist Aims?" in Explorations in Feminist Ethics: Theory and Practice eds. Eve Browning Cole and Susan Coultrap-McQuin (Bloomington: Indiana University Press, 1992), pp. 15-26, affirms the use of principles that are similar, yet different from those of Beauchamp and Childress. She believes that the two principles: "it is wrong to hurt anyone and it is right to sustain human relationships" should guide our actions (17). Her first principle is similar to the principle of nonmaleficence as described by Beauchamp and Childress.


20. Although this is outside the scope of this work's study, gender may be one of the factors in why female-dominated groups are paid less and have less authority than physicians since it has been shown that even in the fields with a higher percentage of females, males make more money.

21. Andrew Jameton in Nursing Practice: The Ethical Issues (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1984) claims that some nurses are "ambivalent about autonomy" and do not consider their "second-class standing" to be a problem because they see it as "safe and undemanding" (47). He does not discuss the possibility that this attitude may be the result of having had autonomy limited and the frustration that may arise from not being able to provide the care that one has been educated to provide.

22. In "Toward a Feminist Conception of Moral Life," in Explorations in Feminist Ethics: Theory and Practice eds. Eve Browning Cole and Susan Coultrap-McQuin (Bloomington: Indiana University Press, 1992), 1-22, Eve Browning Cole warns that it is "perilous to valorize...behaviors that propped up inequalities" (5). In health care situations, then, emphasizing the role of nurturer could be detrimental to a nurse or physical therapist who is involved in ethical decision-making because it may emphasize those qualities which have not traditionally been considered important in a patriarchal society. Cole further cautions against an ethic that is a "mirror of male moral fantasy" which continues to place particularly women in subordinate roles (6).
23. Institutional ethics committees usually have several different health care professionals as members, including nurses, physicians, social workers, or respiratory therapists. However, many of the types of decisions that I am addressing do not get discussed by a committee. Since many patients accept the recommendations of their physicians, these decisions are often made without the benefit of the insight of other nonphysician health care providers. Even on ethics committees, at times nurses are reluctant to disagree openly with the physician who may chair the committee.

24. In "Getting Down to Cases: The Revival of Casuistry in Bioethics," The Journal of Medicine and Philosophy 16 (1991): 29-51, John D. Arras claims that "what gets selected as a case...may systematically ignore[s] genuine cases equally worthy of discussion and debate," and that moral reasoning based on casuistry "suppresses the important global questions bearing on who we are and what kind of society we want" (38, 47). A powerful and possibly detrimental aspect of casuistry and principlism that may be overlooked is whose voices are heard in a case presentation. One of his examples is particularly pertinent to my argument, that is, how health care ethicists neglect the "alternative perspectives on the case held by other participants" (39). There are many participants in health care who are directly and indirectly involved in many dilemmas, and often important viewpoints and perspectives may be overlooked.
Chapter 4

Luce Irigaray's Analysis of Sexual Difference and Feminine Discourse

Introduction

Luce Irigaray's work defies simple interpretation and has been deemed inaccessible by some who have attempted to penetrate and categorize her writing. Irigaray\(^1\) incorporates various aspects of her areas of study, including psychoanalysis, philosophy and linguistics in her work thus providing layers to her work that encourage multiple interpretations\(^2\). Her work exemplifies feminine discourse that I will describe later in this chapter as overflowing with multiple meanings and requiring a sensitivity to new forms of discourse. A feminine discourse will be distinguished from feminine imaginary, with the former being the symbolic form and the imaginary occurring pre-discursively. I will not attempt to use Irigaray's work as a model or framework for an ethical theory, for her work intentionally defies such a use. She does not present a theory of feminine discourse because that would reflect a discourse bound by structure that would limit its possibilities. Rather, I will use some of Irigaray's philosophical observations to help describe and explain some of the recurring ethical problems that arise within health care relationships. Further, by recognizing the significance of gendered discourse in an ethical analysis of health care relationships, Irigaray's work will provide a basis upon which changes in relationships could be promoted so that ethical concerns would be addressed. By revealing the ethical significance of gendered discourse, Irigaray promotes new possibilities of communication. In the final chapter I will use her work
to describe how the institution of health care and the traditional health care ethical methodologies are firmly entrenched within a masculine discourse, and how we can look at this institution and its discourse from a different perspective.

Although I have already described how a masculine discourse has affected health care relationships in the interpretation of principles, obligations, and roles, I will begin this chapter with a further elaboration of the problem of gendered discourse in general. To understand why Irigaray’s work on sexual difference is so profound, it is first necessary to understand the depth to which gendered language has affected society. Masculine discourse is used commonly in society and is accepted as the norm, and therefore its gendered nature is difficult to recognize. Irigaray’s work focuses our attention on the effects that masculine discourse has had on many aspects of society that can be seen in health care in which gender divisions have been accepted as normal.

Before describing Irigaray’s work on sexual difference, the central aspect of her work pertinent for my project, I will discuss her method of uncovering and revealing gendered language. I will discuss how her method of mimesis, or the manner in which she reveals masculine discourse and undermines it, sets her apart from other feminists who also have been able to discern that gendered discourse is detrimental especially to women. Therefore, I first will describe the specific problems regarding the recognition of gendered discourse, and then explain Irigaray’s method for revealing the insidious and dangerous nature of it. By laying this foundation for Irigaray’s unique work on sexual
difference, the depth of the problems associated with gendered language can be explained so that the importance of her work can be better appreciated. Further, without understanding her method of mimesis that she uses extensively throughout her work, Irigaray’s presentation of sexual difference would be even more difficult to penetrate.

After explaining her use of mimesis, I will discuss how masculine discourse has become dominant in society and how it is well-camouflaged as neutral language. Before turning to specific texts that Irigaray uses as examples of masculine discourse, I will explain how historically we have been able to accept a discourse based in the masculine experience as neutral, and how it became representative of society. I will then discuss Irigaray’s engagement with specific texts that not only have exemplified masculine discourse, but also have helped promote it. By using mimesis, Irigaray explores the texts of Freud and Plato whose work influenced generations. Because the psychoanalytical and philosophical writings of Freud and Plato have influenced so much of society, the masculine discourse that is prevalent in their writings is of concern to Irigaray. She challenges their texts that she claims have overlooked or eliminated the female voice from society’s dialogue.

After I explain the problem of gendered discourse, Irigaray’s method of revealing it, the way that language has been made to look neutral, and how historically a masculine discourse has been promoted as the norm, I will then be able to present Irigaray’s theory of sexual difference. I have placed this as the central part of this chapter because the final part of the chapter will be based upon it. In order to be able to discuss a feminine
imaginary or to recognize a feminine discourse using Irigaray’s philosophy, an understanding of her work on sexual difference is first necessary. In the next chapter I will utilize sexual difference to foster a feminine discourse, and to give direction for overcoming some of the ethical problems in health care relationships by observing new meanings in discourse. Her description and celebration of sexual difference allow the feminine voice to be heard and explain how the qualities of woman described with terms such as multiplicity, fluidity, and intermediacy, relate to a discourse that could address the ethical ramifications of interprofessional relationships.

Finally, in this chapter I will return to gendered discourse and describe how Irigaray envisions a feminine discourse that can be elicited from what will be described as a feminine imaginary. She does not advocate a reversal of gendered discourse, but celebrates the differences. Being able to recognize how discourse is gendered and to appreciate the role of sexual difference will be important in the discussion of interprofessional relationships in the final chapter. My ultimate goal will be to apply her work on sexual difference to the ethical concerns involved in health care relationships in a manner that will ultimately be a benefit for patient care. In the final chapter I will explain the importance of using feminine discourse, as described by Irigaray, in addressing ethical concerns that arise from within interprofessional relationships.
Gendered Discourse

Recognition of Gendered Discourse

Since Irigaray has not written a systematic philosophical text, I have chosen specific aspects of her work that apply to the identified ethical concerns involved in interprofessional relationships in health care. I will begin this chapter by explaining the ramifications of gendered discourse on society so that the importance of Irigaray’s work for addressing the ethical problems in health care relationships associated with masculine discourse can be further appreciated.

One of Irigaray’s goals is to sensitize us to the gendered nature of discourse, especially how masculine symbolics have thoroughly inundated our language. Irigaray describes a masculine/feminine dichotomy in discourse that has far-reaching implications. Irigaray explains in *An Ethics of Sexual Difference* (E 1993, written in French in 1984) that

\[\text{[m]an has been the subject of discourse, whether in theory, morality, or politics. And the gender of God, the guardian of every subject and every discourse, is always masculine and paternal, in the West (E 6-7).}\]

Her work reveals the depths to which masculine discourse has reached. It has so thoroughly inundated western culture in all aspects, including religion and health care, that its existence and influence may not be readily recognizable. She asserts that the
patriarchal "symbolic system" is "the one that lays down the law today." Historically, it has been the male voice that has interpreted culture and has controlled how persons interact in society. Not only do our laws reflect the male experience, but the masculine discourse can be witnessed in the political realm as well. Since masculine discourse prevails in the public arena, women's voices and experiences have been relegated to the private and personal realm. Furthermore, she says in This Sex Which Is Not One (TS 1985, written in French in 1977) that "[t]o fail to recognize this would be as naive as to let it continue to rule without questioning the conditions that make its domination possible" (73). Recognizing discourse as gendered is difficult because a masculine voice historically has been the dominant form of language and has been accepted as the norm. We are accustomed to reading, hearing, and using it without consideration of the role that gender might play. One of the problems that Irigaray exposes is that the masculine voice has been established as the identity of the "same" from which all other is derived, especially the voice of woman. This is of particular concern in health care where the masculine voice historically has been dominant.

While so many aspects of society have been affected by gendered language, these effects are not always obvious, and therefore the problems may be obscured and insidious. Because our discourse has taken on a neutral appearance, recognizing the extent and depth of the dominance of masculine discourse is not always apparent. It is difficult to recognize the gender of discourse because historically it has been considered neutral. Over time society accepted the extensive use of the male pronoun even in situations in
which women were involved, because it was used to "represent" both genders. Irigaray claims that:

We are living in an era when, at any rate in most cases, scholars still claim that discourse and truth are neutral, and that the attempt to show that they have a sex and bear sex markers is 'poetry,' 'demagogy,' 'utopia,' 'madness,' 'foolishness,' and so on. The claim is that truth and scientific laws are neutral and universal (E 133).

When women have attempted to change the traditional usage of masculine pronouns or the use of "man" as a suffix, they have often faced derision and obstructions to attempted change. Irigaray explains that one way in which masculine discourse has been disguised is that the male subject is "transformed into the third person." She explains that the gender of language is masked when the subject who speaks is identified by the third person neutral pronoun "it," "they," or by neutral language in which the gender of the subject is lost. For example, a nurse could say, "It is important that you not get out of bed by yourself." The patient may assume that "it" means that the physician has ordered the limitation on movement, but "it" may actually reflect the nurse's judgment. Gender is further concealed with the use of "there is" because the identity of the subject is further obscured. For example, a physical therapist could tell a patient that "due to the type of surgery that was performed, there is a limitation placed on your activities," therefore referring to some unknown entity who places limits on patients. Although the
gender of texts is often not evident because it may have been unconsciously converted into "neutral" verbiage, Irigaray claims that the subject has historically been considered to be male. She claims that "[a]nyone who denies that discourse is sexed is advised to carry out a statistical investigation of taped materials and analyze the results" (E 136). As her work will reveal, masculine discourse has traditionally been accepted as the norm without consideration that the female voice had been overlooked.

In order to unveil woman’s voice, it is necessary that we do not accept the surface appearance of discourse that has been accepted historically by society as neutral. Although Irigaray uncovers and critiques a traditional masculine discourse, she does not advocate an elimination of gendered language that she claims would not be possible. Rather, she provides a mechanism whereby we can recognize the historical influence of the traditional masculine discourse in silencing woman’s voice. Then, based on sexual difference, she discusses how we can learn to hear feminine discourse as well as the masculine one. Further, as Irigaray’s work will demonstrate, feminine discourse sounds different from what is considered the standard, and recognizing it may require an ability to tolerate interpretations that sound unfamiliar. In order to find woman’s voice, one must be able to go beyond what is considered "normal" in western metaphysics. Uncovering woman’s discourse is critical, especially in health care, because communication expressed in a feminine discourse could provide new and unique possibilities for examining ethical concerns that have thus far remained overlooked by the masculine discourse.
Irigaray’s Method of Mimesis

While many feminist writers have sought to reveal the gendered nature of discourse, Irigaray’s remarkable use of mimesis is one of the aspects that makes her work unique. Many feminists have been able to determine places in discourse and society where woman’s voices have not been heard, thus identifying gaps in traditional discourse. Due to the work of these feminists, women’s voices are now heard in places where women were once excluded. However, Irigaray goes a step further than just identifying the places of silence. By using mimesis, she engages the text as a voice from within and reveals where woman’s voice has been interpreted by masculine discourse⁴. She is able to enter the established discourse to critique it without becoming its victim⁵. Through mimesis Irigaray has been able to reveal how writers have helped establish a masculine discourse by either denigrating the value of women’s sexual development or by usurping woman’s voice.

Before addressing specific texts that Irigaray discusses, I will discuss the method of mimesis itself to describe how she reveals the extent to which the feminine voice has been repressed in texts. She says:

To play with mimesis is thus, for a woman, to try to recover the place of her exploitation by discourse, without allowing herself to be simply reduced to it. It means to resubmit herself—inasmuch as she is on the side of the ‘perceptible,’ of ‘matter’—to ‘ideas,’ in particular to ideas about herself, that are elaborated in/by
a masculine logic, but so as to make 'visible,' by an effect of playful repetition, what was supposed to remain invisible: the cover-up of a possible operation of the feminine in language (TS 76).

Mimesis, for Irigaray, is not merely an "imitation" of another's writing, but a conscious assumption of a "sexual stereotype" so that she can work to expose it from within the text (Kozel 1996, 116). If Irigaray's work is read without a sensitivity to how she uses mimesis, it can be misunderstood. Since Irigaray first uses the voice of the writer with whom she is engaging, she may seem to be using the same masculine discourse as the writer. According to Irigaray, it is imperative not to remain outside of the discourse and comment upon its deficiencies. If she were to do that using feminine discourse, her voice would be devalued and she would continue to be seen as an outsider. On the other hand, if she used a masculine discourse, such as that of western philosophy, she would be taking part in the dialogue as a reflection of the established discourse, and be forced into using the masculine voice of the "Same" (Kozel 1996, 118-119). Irigaray's technique of mimicry should be recognized for its subversive strategy that places her in the role of the subject of the text and uses the text as a tool to reinterpret it in a feminine discourse. She intertwines the exact words of a text with her own words that she designs to sound similar, but which are actually quite different in their message. Therefore Irigaray enters the text and assumes a voice derived from masculine discourse in order to reveal the absurdity of its own message. Although I will further discuss her concerns with Freud's work in the next section, the following is an example of Irigaray's
technique in which she mimics Freud's description of the sexual development of girls and boys.

In the first part of mimesis, Irigaray extensively quotes from Freud's writing, and then she interprets it. The following is an example of Freud's statements as written by Irigaray that includes her italics and punctuation:

From the onset of the phallic phase, the differences between the sexes are completely eclipsed by the agreements....THE LITTLE GIRL IS THEREFORE A LITTLE MAN...The little girl uses, with the same intent [as the little boy] her still smaller clitoris...a penis equivalent...man more fortunate [than she]...(These are statements from an essay that Freud wrote entitled "Femininity," according to Irigaray in Speculum of the Other Woman Sp 1985, written in French in 1974, 25).

After presenting a much longer quote from Freud, Irigaray begins her mimetic technique. She repeats just enough of his words to imitate his writing, and then she adds her own interpretation. Irigaray says:

So we must admit that THE LITTLE GIRL IS THEREFORE A LITTLE MAN. A little man who will suffer a more painful and complicated evolution than the little boy in order to become a normal woman! A little man with a smaller penis.
A disadvantaged little man. A little man whose libido will suffer a greater repression, and yet whose faculty for sublimating instincts will remain weaker. Whose needs are less catered to by nature and who will yet have a lesser share of culture (Sp 26).

Irigaray repeats Freud's words just enough that the absurdity of them is apparent. The repetition makes it appear that she is supportive of his pronouncements, yet her final sentence reveals her message. Woman as a partial reflection of man has a "lesser share of culture." Freud's words establish woman's development as secondary to man and by repeating them, Irigaray shows the full force of their negative affect on women. She uses mimesis to disrupt the text she is addressing to allow room for the development of new meanings. She says that she is trying to move "'outside' of this [masculine] imaginary and to allow me to situate myself with respect to it as a woman, implicated in it and at the same time exceeding its limits" (TS 162-163). As I will discuss later in this chapter, this excess has to do with speaking in terms of sexual difference. Therefore, her use of mimesis is used to open a space to allow room for sexual difference to erupt within discourse.

For Irigaray, her writing is a tool in overcoming the domination of masculine discourse, and she embraces the difficulty of this task. She must expose phallocentrism's grip on discourse without becoming a victim of it. By repeating the text's masculine discourse, she runs the risk of being accused of being aligned with the masculine voice. Her use
of mimesis is one of the reasons that her work is so difficult to interpret. It is not always easy to determine when she is repeating the work for emphasis or presenting a counterpoint to the writer with whose work she is engaged. Irigaray’s ability to include multiple meanings in her writing is one of its distinctive aspects. One of the reasons that I began this chapter with a section on recognizing gendered discourse is because feminine discourse is often difficult to recognize and then to interpret.

Irigaray uses her background in linguistics, psychoanalysis, and philosophy to interpret and deconstruct historical and philosophical texts to provide evidence that our language has been and is immersed in masculine discourse. The texts on which she chooses to use mimesis have widely influenced thinking in western society, particularly with respect to gender. She chooses to expose aspects of important and well-known texts, such as the work of Freud and Plato, because they have helped to promote masculine discourse as primary and normative. Irigaray’s varied academic background allows her to use a method of mimesis to respond to Freud’s psychoanalytic account of male and female development, Plato’s use of a female voice, and later in the chapter to Merleau-Ponty and Beauvoir’s depictions of phenomenology, and Lacan’s description of the primacy of the father’s image. She critiques the traditional form of discourse fostered by western philosophical, analytical, and linguistic traditions that she labels masculine, especially as it promotes a singular and fixed meaning.

Although her work on the excavation of gendered discourse is particularly relevant to my
work, she is not unique in being able to identify the role of masculine and feminine discourse in language. However, when Irigaray’s work on gendered discourse, especially her use of mimesis, is considered in conjunction with her discussions of sexual difference, subjectivity, and the self/other relationship, it provides a unique and new possibility for examining some of the ethical problems in health care relationships.

Irigaray’s Engagement with Western Writers

Irigaray’s readings of canonical philosophical texts reveal that the feminine voice is repressed in at least two ways. First, she reveals how the masculine voice has been accepted as the norm in western discourse. As the male voice has become the standard, the female voice has been marginalized as the other and has been placed in a secondary and contingent position to the masculine voice. In the next section I will discuss how she uses the work of Freud to describe how his description of sexual development has engendered this prioritization of the male voice, and how it plays a role in her discussion of sexual difference. The second way that the female voice has been repressed is by western philosophers who have eliminated the female voice from their texts. It is important, according to Irigaray, to study texts not only to interpret the discourse as it is written, but also to try to recognize "what it does not articulate at the level of utterance: its silences" (TS 75). I will discuss Irigaray’s critique of Plato’s use of Diotima’s absent voice as an example of how masculine discourse can manipulate the female voice.
Freud's sexual indifference

In *Speculum of the Other Woman*, and later in *This Sex Which Is Not One*, Irigaray uses the work of Freud to illustrate how the male has been presented as the norm, and how woman has been described as being in a secondary, derivative, and partial position to man. By describing sexual development in terms of the masculine experience, Freud’s work has influenced the continued acceptance of a masculine discourse as primary.

Irigaray works to expose how Freud’s psychoanalytical theories have continued to devalue the feminine voice, and how Freud views woman as a partial man whose development is stunted. She interprets Freud as saying that sexuality is based on a norm qualified by "masculine parameters," in which woman is seen as a partial male who has a "truncated penis" and is "unworthy" because she "has no sex" (TS 63, 39). Freud discounts woman’s sexuality because she has no penis, and does not acknowledge that woman can be sexually fulfilled through her clitoris, breasts, or other sexual organs. According to Irigaray, Freud’s "‘feminine’ is always described in terms of deficiency or atrophy, as the other side of the sex that alone holds a monopoly on value: the male sex" (TS 69). Irigaray explains that Freud does not recognize two sexes. He values only the male and uses the penis as the standard of sexuality. Woman, according to Freud, is only partial and deficient with her sexuality described in terms of a "truncated penis." Freud does not recognize that woman may have her own sexuality, and Irigaray calls this attention to only one sex, "sexual indifference" (TS 69). By using mimesis, she uses Freud’s statements again to illustrate how Freud devalues woman’s multiple sites of
sexuality. She asks:

what male ‘organ’ will be set forth in derision like the clitoris?—that penis too tiny for comparison to entail anything but total devaluation, complete decathexization. Of course, there are the breasts. But they are to be classed among the secondary, or so-called secondary, characteristics (Sp 22-23).

Irigaray uses mimesis here by assuming a voice that seems to claim the female body as devalued, but she is actually deriding Freud’s analysis. Therefore, she does not use an outsider’s voice to make a claim for superiority, or even equality, of the woman’s sexual organ in the libido’s development. She does not set the clitoris in opposition to the penis. If she were to do that, her work would be seen as that of the "other" and only considered as a critique of Freud from the margins. She uses mimesis and repeats his own words that devalue woman’s sexuality, but then she addresses male sexuality in terms of deficiency. She says:

one might be able to interpret the fact of being deprived of a womb as the most intolerable deprivation of man, since his contribution to gestation—his function with regard to the origin of reproduction—is hence asserted as less than evident, as open to doubt (Sp 23).

In this way she can expose man’s biological deficiency of not having a womb that she
interprets as placing him in a secondary role in reproduction. By engaging Freud from within his own text, Irigaray can specify where Freud has overlooked particular aspects of woman's development. He concludes that the "primacy of the penis" and "the necessarily masculine character of the libido" (TS 35) develop together. It is important for Irigaray to demonstrate the value of sexual development as it differs for women and men, because Freud so carefully has laid out a theory claiming that both sexes develop in the same manner. Because Freud's work has been studied so extensively throughout western culture, one of the results of his devaluing of the development of women is that it reinforced the superior position of the male in discourse and culture.

Irigaray further exposes Freud's impact on the understanding of woman's development in relation to the other and explains that psychoanalysis continues to reinforce "the movement to speak of the 'other' in a language already systematized by/for the same" (Sp 139). Therefore, it is difficult for feminists to describe a feminine discourse that represents the other because the masculine discourse already has done so from its perspective. This is one of Irigaray's main criticisms of Freud's work. His psychoanalytic work leads him to conclude that the early sexual development of the genders is similar, but that the female body makes her deficient in comparison to the male. Irigaray refers to his theory of sexuality as "sexual indifference" that had been "operative all along though it remained implicit, hidden, unknown" (TS 69). His "sexual indifference" is revealed through his focusing on the development of the male without consideration that the female development could be different and valued separately from
the male's. Because Freud does not consider the sexual differences between the sexes as important, he then is able to place the male as the signifier of the same with the atrophied female as the other. By emphasizing the normative value of the development of the male, Freud places woman in a secondary or contingent position relative to the male. "All Freud's statements describing feminine sexuality overlook the fact that the female sex might possibly have its own 'specificity'" (TS 69). Freud's work has influenced the psychological development of woman and has played a role in the societal devaluation of women and their discourse. His psychoanalytical writings placed the male in the normative position, thus assigning the female to the lower, other place. He did not consider that the sexual differences between the genders allowed the potential of both sexes to develop differently, without the female being contingent upon the male.

While Irigaray disagrees with many of Freud's conclusions, she does not distance herself from the field of psychoanalysis or Freud's entire body of work. She does not wish to "return to a precritical attitude toward psychoanalysis, nor claim that psychoanalysis has already exhausted its effectiveness" (TS 72). As an analyst Irigaray works to disrupt what has been accepted as fact or truth in the western psychoanalytic tradition by trying to recover sexual specificity for women. She appreciates certain aspects of the analytic tradition, including Freud's "stressing deferred action...", his emphasis on sexual development and the importance of delving into the unconscious realm (TS 72). However, she wants psychoanalysis to be able to extend outside of its boundaries created by its theories. She has identified areas, especially in the development of woman's
sexuality, that need further investigation. Irigaray notes that some female analysts tried to influence Freud and were minimally successful in getting him to re-evaluate some of his findings, such as, "the issue of the girl’s pre-Oedipal phase" (TS 46). However, Freud continued to "react--negatively to the research analysts who rebel against the exclusively masculine viewpoint that informs his own theory" (TS 49). It is this specifically masculine viewpoint, including Freud’s "giving a priori value to Sameness" and asserting that "the ‘masculine’ is the sexual model," (TS 72) that has influenced culture and discourse that Irigaray is working to disrupt.

**Plato’s use of Diotima’s voice**

In addition to describing how texts have placed the male as the norm in the superior hierarchical position, Irigaray also describes how philosophers have repressed feminine discourse by eliminating woman’s voice from the text. Her methodology involves listening for woman’s voice in texts and recognizing where her voice is absent. Irigaray argues that masculine discourse cannot effectively represent woman’s voice, and therefore if we are sensitive to lacunae in discourse, we may recognize feminine discourse emerging. She searches texts for gaps and silences where woman’s voice is eliminated by masculine discourse. She says that we must

[i]nsist also and deliberately upon those blanks in discourse which recall the places of her exclusion and which, by their silent plasticity, ensure the cohesion, the articulation, the coherent expansion of established forms (Sp 142).
Irigaray proposes that we should search texts to find evidence of the masculine voice being considered the norm and the feminine voice being repressed. Irigaray uses Plato’s *The Symposium* to examine how woman’s voice is absent and yet represented by a male voice. Although words are attributed to a woman by Plato, Socrates speaks for Diotima even though she is not present and therefore cannot speak her own words. This could be interpreted as a positive situation for women since Plato has placed Diotima in a position of teacher for those in attendance at the dinner party. However, Irigaray is suspicious of Plato’s attributing words to a woman and then not allowing her to be present to speak. Irigaray is concerned that Plato is using Diotima to further his philosophical agenda.

Irigaray describes Diotima’s change in her description of love in the midst of the lesson being provided to the guests of the party. She discusses how Diotima’s voice is usurped by the masculine discourse when in the discussion of love between Diotima and Socrates, Diotima’s basic description of love changes from one of an intermediate state to a "teleological quest" in which procreation of a child becomes a goal of love and eventually results in a love of beauty and knowledge (E 31). An intermediate position is important for Irigaray because it involves providing a medium for something to develop and may be described with terms indicating movement and growth. Her use of the term "intermediate state" is an important aspect of her description of sexual difference and feminine discourse. According to Irigaray, Diotima’s first words of love are full of a sense of becoming and fecundity; "Love is thus an intermediary between
pairs of opposites" (E, 24). Diotima describes love as daimonic; that is, "[b]eing of an intermediate nature" in which it has the nature of a spirit, neither man nor god (Plato 1973, 81). Although I will describe her use of intermediacy and feminine discourse later, I bring up the intermediacy of love now to give an example of how Irigaray interprets Diotima’s lesson as changing from a discourse full of feminine images to one that resounds more with the masculine voice.

How Diotima’s words can be interpreted both for what they say and what they leave unsaid is of major concern to Irigaray. She questions the use of Diotima’s voice to describe love and says that perhaps in Socrates’ reporting of Diotima’s words, he "distorts them unwittingly or unknowingly" (E, 27). However, Irigaray then proposes that Socrates intentionally uses Diotima’s voice to help undergird Plato’s metaphysics. Irigaray interprets Plato’s manipulation of Diotima’s words as having her endorse love’s quest of beauty and the perception of "one single knowledge" (E 31). Thus, Irigaray claims that Socrates uses Diotima’s absent voice to endorse his message that reflects the masculine voice.

According to Irigaray, Diotima’s words signify a change from a feminine discourse based on openness and becoming to a goal-oriented masculine discourse based on achieving a specific outcome. While Irigaray is critical of this change during Diotima’s discourse, she is able to rehabilitate the outcome of Diotima’s teaching by interpreting her description of love as continuing to have features of mediation similar to what she calls
a "sensible transcendent" that I will discuss later. Therefore, typical of Irigaray's work, she leaves an opening for multiple interpretations. She can interpret Diotima's words as a "risk of being reduced to the metaphysics that is getting set up," and in the very next sentence say: "Unless what she proposes to contemplate, beauty itself, is seen as that which confounds the opposition between immanence and transcendence" (E 33). Therefore, Irigaray allows multiple interpretations, including one that would make Diotima a spokesperson for Plato and one that speaks in a feminine discourse that disrupts the established dichotomy between immanence and transcendence. By using feminine discourse, Irigaray encourages an openness that allows multiple interpretations of why Plato uses Diotima's voice even though she is not present.

**Irigaray's Interpretation of Sexual Difference**

Irigaray's interpretation of sexual difference is a critical component in her discussion of gendered discourse. Her analysis of sexual difference focuses on the body from phenomenological, psychoanalytical, philosophical, and social perspectives. According to Irigaray, humans develop, not only based on their genetic components, but also in reaction to and in interaction with culture and society. What makes her work unique among feminists is her recognition that the cultural and societal influences on the development of women are related to interpretations of the body. She wants to lift the veil on sexual difference in order to celebrate the qualities of women's bodies that have been both overlooked and denigrated by a masculine discourse in society. Irigaray explains that woman's social development has been affected by gendered discourse,
especially since a masculine discourse has permeated society as the norm. Social practices have been deeply affected by a discourse that devalues women’s bodies so that practices detrimental to women have become unconsciously accepted by society.

**The Phenomenology of Woman’s Body**

**Merleau-Ponty’s influence**

Irigaray recognizes the importance of deconstructing the social meanings grounded in phallocentrism that have been so widely accepted. She does not develop a theory based on the equality of the sexes, and neither does she place woman hierarchically above man, because either of these alternatives would reinforce a masculine discourse based in sameness. Instead, Irigaray sees value in a celebration of sexual difference, by interpreting woman’s body as different and valuable in its own right. Irigaray is indebted to Merleau-Ponty for his work in phenomenology that she utilizes in her analysis and interpretation of the lived body⁹.

Although the biological differences between the sexes are obvious, the interpretations of them have been obscured by masculine discourse. Irigaray draws sexual difference to the forefront so that the unique qualities of woman can be appreciated and celebrated as they reveal what has been hidden by a discourse that focuses on sameness. Women have been interpreted for too long through a discourse that does not reflect the unique experiences of their bodies. Irigaray says: "That we are women from the start. That we don’t have to be turned into women by them, labeled by them, made holy and profaned
by them" (TS 212). Our bodies can speak for themselves if we recognize the importance of their value and their relation to discourse. She uses a phenomenological approach to bring about a "possible recovery in lived experience of a feminine pre-predicative" (Godway 1993, 21). By using phenomenology Irigaray argues that the way woman experiences her sexual body in the world can lead her to recognize what she may already sense in her unconscious. Irigaray explains that the sexual indifference of masculine discourse has led to the acceptance of the masculine as the norm in discourse, society, and culture.

One of the aspects of Merleau-Ponty’s work that Irigaray finds applicable to her work on sexual difference is his placement of the visible lived body’s experience in the world in relationship with the invisibility of the unconscious. By placing consciousness in the lived body, Merleau-Ponty overcame the Cartesian separation of mind and body that is important for understanding the relationship of sexual development to consciousness. Irigaray, including a quote by Merleau-Ponty, says:

Up to this point, my reading and my interpretation of the history of philosophy agree with Merleau-Ponty: we must go back to a moment of prediscursive experience, recommence everything, all the categories by which we understand things, the world, subject-object divisions, recommence everything and pause at the ‘mystery, as familiar as it is unexplained, of a light which, illuminating the rest, remains at its source in obscurity’ (E 151).
Merleau-Ponty argues that our lived bodily experiences in the world are integrated with our perception\(^\text{13}\). He says:

Our perception ends in objects, and the object once constituted appears as the reason for all the experiences of it which we have had or could have (1962, 67)....We must discover the origin of the object at the very centre of our experience (71).

According to Bannan, the object "is essentially a structure for consciousness," and an object must exist for there to be a consciousness of it. This observation is particularly important in understanding Merleau-Ponty's discussion of the body as subject. Merleau-Ponty, referring to the body, says: "What prevents its ever being an object, ever being 'completely constituted' is that it is that by which there are objects" (1962, 92). The body as subject does not cause there to be objects, but because consciousness is part of the body, there is a "dialectical relationship" between the object and the body (Bannan 1967, 64). Therefore, since the lived body is experiencing the world at the same time that it is perceiving it, Merleau-Ponty says that it can only be a subject.

Irigaray also argues for subjectivity being a part of the experience of the body with the world. She, however, describes how woman has been made to be an object by the masculine discourse. Irigaray's use of Merleau-Ponty's phenomenology will be evident when I discuss her concerns regarding woman's objectification. Further, Irigaray
recognizes that since female and male bodies are different, they then have a different experience and relationship with the world around them.

Since Irigaray claims that woman has been described through masculine interpretations, she explains that feminine discourse based on sexual difference would provide a means for women's bodies to be understood from a new perspective. The differences in the sexual centers of pleasure of women and men, and how these result in different relationships with the world, are used to formulate much of her discussions about sexual difference. Differences in the sexes have been overlooked or downplayed by writers, such as Freud who describes woman as partial, incomplete and as having no sex organ at all. When the differences in sexuality are denied, woman's sexuality is then ascribed meaning through the male version of sexuality. In je, te, nous (Je, 1993, originally published in French in 1990), Irigaray criticizes those who would "neutralize" sex, including feminists and explains the importance of sexual difference. She says:

This neutralization, if it were possible, would mean the end of the human species. The human species is divided into two genders which ensure its production and reproduction. To wish to get rid of sexual difference is to call for genocide more radical than any form of destruction there has ever been in History. What is important, on the other hand, is to define the values of belonging to a gender, valid for each of the two genders (12).
Irigaray points out more than the obvious biological fact that it takes both genders to procreate for the world to continue. She is concerned with how the female gender as represented in society has been devalued by a discourse that does not recognize the existence of two different genders, each with its own unique qualities and value. Therefore, both sexes need to be recognized for their specificity in order for each of them to be respected. Irigaray refers to the use of only the masculine gender by writers as sexual indifference and claims that this use causes the masculine gender to be universally accepted as more valuable. This is then transferred into masculine discourse where the male dominates "directly or indirectly, to give the universe his own gender as he has wanted to give his own name to his children, his wife, his possessions" (Je, 31). Therefore, unless sexual difference is recognized so that the female body is valued for its specificity, feminine discourse will remain obscured.

Interpreted qualities of the female body

In her discussion of sexual difference Irigaray emphasizes differences in qualitative descriptors of the bodies of the sexes. Irigaray’s presentation of the female body has been interpreted in many ways. I will begin with her description of the relationship between fluid and woman’s body. Although Irigaray at times uses biological terms to identify body organs, her approach is based on phenomenology in which the interpretation of the body is the focus. She does not attempt to prove that woman’s body is more fluid than man’s, since she is more interested in the interpretation of woman’s interaction with the world. She describes the physical relationship between fluids and
solids and then constructs a comparison based on the interpretation between the fluid nature of woman's body and man's solid form. Irigaray claims that in both physics and western metaphysics precedence has been given to solids over fluids which is another reflection of masculine discourse.

According to Irigaray, the female body has some of the characteristics of fluid due to her multiple sites of sexual pleasure as opposed to man's singular sex organ, the penis. She describes how the bodily fluids of blood and mucous are a larger part of the woman's experience with the world, and how woman's biological fluids have always been considered taboo and are usually hidden. Irigaray describes woman's bodily fluids as "the flow of some shameful liquid," and the "'subject'...finds everything flowing abhorrent" (Sp 237). She associates solids with phallocentrism due to their stability, rigidity, form, and capability of being enclosed into a singular arrangement. Fluid, on the other hand, is "continuous, compressible, dilatable, viscous, conductible, diffusable..." (TS 111). Irigaray uses this description of the property of fluid to describe woman that would keep her from being reified as one solid piece of matter that could then be used by another. Woman is like fluid; she is uncontained, mobile, free-flowing, and without boundaries and "never closes up into a volume" (Sp 239). Her half-open sexual organs, Irigaray calls the two lips, make her unable to be in a closed state or container. Irigaray uses the description of woman as fluid and uncontainable to argue that it would be impossible for her to be the reflection of a fixed entity that would place her in the role of the other.
When Irigaray describes the multiplicity of woman, she is interpreting the meaning of the various erogenous zones of woman that provide multiple sites of pleasure. She places them in opposition to the penis that she uses to symbolize western philosophy’s emphasis on singularity. Although multiplicity is an important feature of Irigaray’s embodied philosophy, she clarifies that "woman remains several but not dispersed" (TS 31). It is important not to describe woman as so mobile and undifferentiated that she becomes divested of an identity. Multiplicity does not mean that woman is scattered, but that she can experience the world freely and without rigid boundaries. Irigaray uses the term "nearness" to describe woman, as represented by her two lips, that have "boundaries [that] touch against one another while still remaining open" (E 51). This nearness does not indicate ownership, but rather an exchange that involves movement and flexibility that are not inherent properties in a philosophy based in phallocentrism.

Because of the uncontrollable nature of fluid, Irigaray’s description of woman could be considered dangerous in the economy of the same. If woman has properties that promote multiplicity and instability, metaphysics as we know it would be ruptured. That is why Irigaray claims that "[t]he object of desire itself, and for psychoanalysts, would be the transformation of fluid to solid? Which seals - this is well worth repeating - the triumph of rationality" (TS 113). She argues that solids can be controlled more easily than fluids, and therefore a phallocentric tradition would not tolerate a feminine discourse that is as multiple and unstable as fluid because it then could not be controlled by the masculine subject and merely be its reflection. In order to understand Irigaray’s goal of finding a
new feminine imaginary and symbolics, it is necessary to recognize descriptions of woman other than the one that traditionally places her as a mirror of the male and serves as a place for male symbolics.

Fluid is often a medium where interactions occur since its properties of movement allow it to be a place of connection. It is the intermediate state between solid and gas. Since woman's body can be associated with the properties of fluid, she also can serve a role of intermediary who can move freely between persons or substances. As an intermediary, woman is in a position of creating and assisting in change since she is like a fluid that is less fixed and more dynamic in its interactions with others. The role of motherhood is a form of an intermediate status in which woman plays a temporary host to a new human being and will be further discussed later in this section. As a mediator, woman finds herself in the "economy of the interval" where Irigaray places desire (E 8). She does not define desire as the place designated between man and woman, but rather as "the remainder that subsists after each creation or work" (E 8). Irigaray is not satisfied with enclosing woman's desire or description within boundaries, for she views woman as "residue," or something that is in excess of designations, especially when they arise from within a masculine symbolic system. Irigaray describes woman's sexual difference in terms of fluidity and multiplicity, and as such, woman exceeds or overflows the boundaries established by a masculine discourse that is enveloped within fixed boundaries. Woman escapes the phallocentric order, into the undescribed interval in which woman may be allowed her own imaginary.
In addition to associating woman’s bodies with fluid, Irigaray also recognizes that there is a relationship between space and woman’s experience of mobility. Although traditional discourse has designated woman as place, Irigaray describes how woman’s body is not closed within boundaries and therefore resists being confined to a specific space. She returns to the description of the body, specifically the female sexual organs, which are composed of an opening surrounded by two lips. Irigaray describes "a threshold that is always half-open. The threshold of the lips, which are strangers to dichotomy and oppositions" (E 18). Irigaray uses this description of the female body to express how two forms can come in contact without opposing each other. She emphasizes the freedom of a woman’s body that is not enclosed by boundaries. When her body is considered, woman should be associated with openness, movement, and fluidity, rather than space or a closed container. Instead of remaining in a fixed place, Irigaray associates woman’s body with movement and becoming that allows freedom and independence.

If woman were restricted to filling a space established by the masculine discourse, her freedom of movement and language would be limited. Woman’s experience of multiple sites of sexuality is interpreted by Irigaray as being representative of how a feminine discourse resists being enclosed by a single interpretation. Her writing also reflects qualities of fluid, since it can be described as "uncontainable." Therefore the multiple interpretations of her work are unavoidable since the fluidity of her writing can allow and promote a "proliferation of readings" (Whitford 1991, 101). This multiplicity of
interpretations reflects woman’s body that symbolizes an overflowing and the inability to contain its meaning.

**Woman’s maternal function**

Although Irigaray often writes of the maternal-feminine, she emphasizes that the importance of woman is greater than her ability to bear children. She asks: "when will they cease to equate woman’s sexuality with her reproductive organs…" (Sp 146). She recognizes that a woman’s value has often been associated with her maternal nature and that "man, consciously or unconsciously, feeds on and exploits the maternal-feminine in order to live, survive, inhabit, work…" (E 142). Irigaray recognizes the significance of woman’s child-bearing abilities, but more for its interpretative value than for its biological status. Irigaray criticizes Freud’s emphasis on the value of child bearing because he claims that having a child, especially a male child, is the way in which woman fills some of her sexual deprivation.

Irigaray interprets maternity differently than separation or as a completion. Maternity for woman is about nearness, openness, and not having boundaries, and the child represents movement and becoming, not a form of property. In Freud’s interpretation, maternity is a means for a woman to find completion. For Irigaray, child-bearing represents a dynamic process in which woman participates as a mediator in another being becoming human. Rather than depicting a pregnant woman as a container or a "volume," Irigaray reminds us that "woman’s ability to enclose is enhanced by her
fluidity" and "[o]nly when coopted by phallic values does the womb preclude the separation of the lips (Sp 239). Maternity places woman in a position of mediating the becoming of new life. This positive association of woman with the natural process of childbirth reverses the trend in early feminism that "stressed the oppressiveness of motherhood as an institution" (Stanton 1989, 159). Rather than devaluing this powerful quality that is unique to women, Irigaray recognizes that masculine discourse has interpreted maternity differently than a feminine discourse that would celebrate its role in creation. Irigaray uses the maternal-feminine, similar to her use of fluidity, to interpret woman’s body as a dynamic center of growth and becoming.

Irigaray and Essentialism

Sexual difference is a complicated issue and has been both criticized and celebrated by feminists. In the first wave of feminism the emphasis was placed on eliminating the differences between males and females in an effort to attain equal rights and treatment. As representative of this era of feminism, Simone de Beauvoir claimed that women became women via social construction and not through biology. This early feminism fought against being identified as biologically female because woman traditionally had been considered the weaker sex. There was an effort to be more like men to be able to achieve social equality. Early feminists not only tried to act like men, but used masculine discourse to appear similar to men. Therefore, women were encouraged to downplay their sexuality and their maternal function, in an effort to try to work for equal status with men.
In later feminism the female body was acknowledged and celebrated for its differences from the male biological body. There is no denying that women and men are different biologically, and woman’s ability to bear children particularly sets her apart. While this wave of feminism celebrated female sexuality, they continued to face discrimination since the feminine was not valued equally in a society dominated by masculine discourse. According to Irigaray, this discrimination occurs because only the male sex is valued by society and those variances from the masculine norm are assigned a lesser value. For example, when pregnancy is considered an illness, woman’s natural abilities are interpreted as being abnormal. Her project of mimesis uncovers these biases of masculine discourse that have dominated society to a point that discrimination may not be realized. Her work is unique in how it celebrates feminine qualities without speaking from the margins in the voice of the other or by allowing them to be overlooked by the masculine discourse of society.

Irigaray has been accused of being an essentialist based on her work on sexual difference. Rather than denying the differences and claiming equality, Irigaray acknowledges the differences in male and female bodies and endeavors to make those differences meaningful for a discourse that is recognizable to both genders. How Irigaray "mediates between radical essentialism and radical constructionism" lies in her phenomenological approach to sexual difference (Moscovici 1996, 23). Sexual difference for Irigaray involves interpreting and celebrating the unique qualities of woman’s body that make her experience in the world different from that of a man’s. While Irigaray
promotes sexual difference, she does not want woman to be valued solely for her biological capabilities. She emphasizes sexual difference based more on the qualities associated with the female body and how those affect woman's relation to the world. Her mimetic analysis of the work of Freud and several western philosophers reveals how masculine sexuality has been the foundation of the dominant masculine discourse. Although Irigaray's descriptions of the differences between the sexes are based on biological differences, her work is important for its emphasis on the meanings of these differences and their interpretations rather than a literal biological comparison of bodies. According to Irigaray, recognizing the importance of sexual difference and the celebration of the female body provides a tool for uncovering a female imaginary and discourse.

Irigaray's use of mimesis necessitates describing the body in its sexual specificity so that she can uncover how the phallocentric tradition has used the male body to maintain the dominant position in discourse. Her tactic of using morphology has been rebuffed by some as promoting essentialism. Ping Xu claims that "Irigaray is in fact mimicking the discourse that has always been fabricating essentialist and 'sexed' 'facts' and 'truth' about female (as well as male) sexuality" (78). Therefore, with mimesis Irigaray uses the same tactics and methods to describe female development as Freud and others have used, but she arrives at a much different conclusion. Because Irigaray's feminine discourse is necessarily ambiguous and fluid, it is open to multiple interpretations, including that of essentialism. Because of its ambiguous nature, Irigaray's work can be interpreted both
as that of an essentialist and as a critique of the essentialism of male writers.

**Irigaray and Subjectivity**

Irigaray describes a gendered subjectivity from a phenomenological approach as being a reflection of the experience of the lived body. Subjects have the ability to communicate their personal experiences through their relationship with the environment and context. Because masculine experience has influenced the discourse of society, Irigaray explains how males have functioned as the subjects, and because women’s bodies and experiences are devalued, women have been placed in the position of object. Therefore, the terms "male speaker" and ‘subject of knowledge’ become interchangeable descriptions" (Schutte 1991, 66). Irigaray says that "he thus becomes the ‘sun’ if it is around him that things turn" (Sp 134). According to Irigaray, man as subject is the interpreter of the world around him. Woman, then, has been excluded from participating in the exchange of knowledge and the development of societal laws. Further, it is difficult to change positions for woman because she "lives her body as object as well as subject" (Young 1990, 155). This occurs because woman has been defined by the traditional discourse of society as an object, and she has learned to experience the world from that viewpoint. As an object she has been precluded from participating in the interpretation of the world.

As objects, women's voices are silenced by the male subject who has control of the object. Irigaray says that
In our social order, women are ‘products’ used and exchanged by men. Their status is that of merchandise, ‘commodities.’ How can such objects of use and transaction claim the right to speak and to participate in exchange in general (TS 84)?...A woman ‘enters into’ these exchanges only as the object of a transaction, unless she agrees to renounce the specificity of her sex, whose ‘identity’ is imposed on her according to models that remain foreign to her (TS 85).

Irigaray’s project entails uncovering a feminine discourse grounded in an interpretation of the body so that women do not have to denounce their sexuality in order to speak or be heard. In the silences of texts and discourse, Irigaray has realized that woman is "absent as a subject" (TS 94). Because it promotes a sexual indifference, the psychoanalytic tradition has led to a "woman’s nonexistence," so that she cannot experience the world and cannot be a subject. Her role as mother, according to the psychoanalytic tradition, is the only way that she has been able to become existent, as something of value (TS 102). Irigaray explains how woman’s role as mother has helped objectify her because she "represents a place for man, [and] such a limit means that she becomes a thing" (E 10). As mother, a woman’s traditional role revolves around the children and the home where she is available to provide for the needs of the children. It is Irigaray’s interpretation of woman’s traditional role as mother as specified by masculine discourse, not a specific description of her activities, that places woman in a fixed position, or a place, of responsibility for the child. Furthermore, by being interpreted as a place by masculine discourse, Irigaray describes how woman can then
be ascribed the qualities of a solid in a fixed position. Although Irigaray recognizes the value of woman in her maternal role, she discusses how woman's body allows her to experience the world in ways differently from men. She explains that woman's sexual differences provide her with a unique relationship with the world in which she is both multiple and intermediate in nature that traditionally had not been valued by western metaphysics. She must "reinvent" woman's subjectivity\(^ {20} \), not by using masculine parameters, but rather by recognition of woman's unique experience in the world because of her sexual difference.

**Self/Other**

*The relationship between subject and self*

Irigaray explains that the masculine subject has much at stake in keeping the division between the subject and object, for there "is the risk that the subject (as) self will crumble away" (Sp 135). She recognizes that there is a relationship between the position of the subject and the self, and that the self maintains itself in the superior position by relying on the reflection of the other to reinforce it. Therefore, if the self cannot maintain its place situated in sameness, the subject could dissolve if it is dispersed in a reflection of multiple images. Irigaray recognizes how the subject, a metaphysical entity that interprets knowledge, often holds the place of the same in the same/other relationship. Irigaray explains that in a masculine discourse that defines the roles of the subjects and objects, "She must continue to hold the place she constitutes for the subject, a place to which no eternal value can be assigned" (Sp 227). Because the male voice of
the subject traditionally has maintained the authority to interpret the world and its laws, and therefore assigns value to all things, the feminine object has fulfilled a position of reflection and inferiority. The relationship between subject and the object is based on an interpretation of knowledge, that is, subject and object are defined not by how they relate to each other, but rather, how they are determined separately by an interpreted discourse. However, the relationship between self and other is established in relationship to each other, as the other is determined by the self’s position and self-recognition.

**The other as mirror image**

Irigaray says that traditionally the subject has established itself firmly in the position of self by use of the reflection of self-images in order to reinforce the position of dominance. She says that in

the system of his relationship to the self, the closure of his auto-representations, focus of his lonely exile as ‘subject.’...[H]e becomes a prisoner of effects of symmetry that know no limit. Everywhere he runs into the walls of his palace of mirrors...(Sp 136-137).

In addition to mimetically addressing Freud’s work, Irigaray similarly responds to Lacan’s description of a woman being the reflection of man as a mirror image. She turns from Freud’s psychoanalytic repression of the woman’s voice to a linguistic one in which Lacan identifies the self "as that position in the process of speaking from which
the speaker establishes a relation to an other" (Allen and Young 1989, 6). Lacan uses an image of a mirror in which the other, as the reflection in the mirror, becomes the "alter ego" of the subject that is established as the self21. According to Lacan, the reflection can either be one of "likeness or distortion" (Allen and Young 1989, 6). He says that in the imaginary aspect of language22, the self is linked with the mother, but in the symbolic aspect of language, which "relates the subject to a reality other than itself" and is translated into the masculine discourse, the link is through the father23. Irigaray criticizes this link with the father, which Lacan says becomes the "absolute signifier, the phallus," and "is accompanied by the repression of the emotional nexus of the mother-child relation and the opening up of the unconscious (Allen and Young 1989, 6). Irigaray compares Freud’s psychoanalytic description of woman as lacking a penis to Lacan’s linguistic account as "not so much the penis--a real organ--as the phallus, or the signifier of desire" (TS 61). Therefore, while the biological penis is used to establish the psychological norm upon which sexual development occurs, the phallus24 for Lacan represents the linguistic interpretation of "a rough non-verbal emblem of need, demand and desire" (Bowie 141). This places the problem with Lacan in the symbolic realm where the problem becomes woman’s lack of desire. Irigaray says that

we might suspect the phallus (Phallus) of being the contemporary figure of a god jealous of his prerogatives; we might suspect it of claiming, on this basis, to be the ultimate meaning of all discourse, the standard of truth and propriety, in particular as regards sex, the signifier and/or the ultimate signified of all desire,
in addition to continuing, as emblem and agent of the patriarchal system, to shore up the name of the father (Father) (TS 67).

In a phallic economy the penis assumes a much broader interpretation in which it "comes to symbolize value, limit, measure, authority, the law" (Schutte 1991, 71). When woman is placed as the other without phallic signification, she forfeits a position in the dominant phallocentric discourse. More than not having a penis, woman in a phallic economy, is without voice or value.

Irigaray further addresses how being a mirror image affects woman as she is placed in the role of other. The problem with describing woman as a mirror image of man is that as a reflection, woman is regarded as incomplete and inferior. The subject is recognized as the self who holds the mirror, but the object is the other in the reflection of the mirror. In an Irigarayan interpretation of how masculine discourse has affected the relationship between persons, the subject's voice is the one that is heard and whose discourse directs the action of the object. Similarly, the self is the speaker and the other's voice is derivative and contingent upon the self. Therefore, it has been difficult to discover a true feminine discourse since it is mediated through the masculine self.

In her style of mimesis Irigaray quotes Lacan who says that

There is no woman who is not excluded by the nature of things, which is the
nature of words, and it must be said that, if there is something they complain a lot about at the moment, that is what it is—except that they don’t know what they are saying (TS 87).

Irigaray interprets his words as meaning that

Women are in a position of exclusion...Their exclusion is internal to an order from which nothing escapes; the order of (man’s) discourse (TS 88).

The reason that Lacan argues that woman does not know what she is talking about is due to the fact that she is a victim of masculine discourse in its exclusion of her. She is excluded from discourse because she is a mirror image of man and cannot speak her own language. Lacan’s placement of woman as the mirror image does not allow woman a voice, and thus, similar to Freud’s position, she is nonexistent because she cannot communicate her own words. Her absence can only be overcome by maternity; by bearing a child. According to Irigaray woman is made to be a

‘receptacle’ [that] receives the marks of everything, understands and includes everything—except itself—but its relation to the intelligible is never actually established. The receptacle can reproduce everything, ‘mime’ everything, except itself: it is the womb of mimicry (TS 101).
Here Irigaray is using "mime" as a means of imitation, or as a reflection of the same by the other. However, Irigaray uses mimesis as a means to undermine discourse and argues against Lacan’s using woman as a receptacle to be "marked" without the ability to relate to the world as subject. By using sexual difference Irigaray describes the uniqueness of woman who has the ability to speak with her own voice and knowledge, which is denied with this description. She responds with a description of woman who has her own identity and whose voice comes from a feminine imaginary.

Feminist interpretation of self/other

Identifying and overcoming the hierarchical nature of the self/other relationship historically has been a goal of feminism, especially Simone de Beauvoir who described woman as the other of man. One of the major differences in Beauvoir’s work and Irigaray’s is how Beauvoir associated male experience with humanity and transcendence. According to Beauvoir, one had to assume masculine qualities in order to achieve transcendence. Although Beauvoir acknowledged woman’s experience, she devalued it. Beauvoir’s work is important in the history of feminism because it alerted us to the separation of self and other based on gender. However, her work can be criticized for its maintenance of the hierarchy of man and woman with the male in the superior position.

The problem with Beauvoir’s work, according to Irigaray, is that when women tried to deny their specifically feminine qualities in order to achieve equality with men, women
experienced a dissonance in their lived experiences. Women recognized that their unique experiences based on their sexual difference should be acknowledged, and they should be valued as subject and self. Carol Gilligan's work described woman's moral development as being equal but different than man's. Although Gilligan's work seemed closer to Irigaray's in its celebration of woman's experience, there were problems with it because it functioned within the masculine discourse that controlled the definitions and values in society. Because Gilligan used the discourse of her male colleagues, her work was marginalized by the dominant masculine discourse and has been acknowledged mainly within feminist circles. Irigaray's work provides a bridge by using sexual difference to express the value of woman's lived experience in a feminine discourse.

Irigaray's speculum

Irigaray searches for a way in which woman no longer must be the mirror that allows man to see himself. Woman can never see herself except through the reflection in him, for "woman cannot place herself as an object for herself" (E 69). Therefore, woman is not represented and never speaks from her own identity. Historically, the feminine is either interpreted by another or obscured. Irigaray says:

Woman has no gaze, no discourse for her specific specularization that would allow her to identify with herself (as same)...Hence, woman does not take an active part in the development of history, for she is never anything but the still undifferentiated opaqueness of sensible matter, the store (of) substance for the
sublation of self, or being as what is, or what he is (or was), here and now (Sp 224).

Irigaray strives to overcome the hierarchical self/other relationship without succumbing to the masculine discourse of the same. In response to Lacan's mirror image, Irigaray uses images of the speculum. True to her emphasis on multiplicity, she utilizes the term speculum to mean a variety of things. The speculum can be a tool for which man can peer into the depths of woman's bodies to try to see what is hidden. This instrument can be an "expression of the drive to measure, survey, or give definition to what is other than himself...reducing the other's meaning to that projected on it by the subject" (Schutte 1001, 68). In this use of speculum the subject observes the biological difference in the female from outside without understanding its value. She also uses speculum to describe woman as a "concave speculum" where man sees his own reflection that is "[i]nﬁnitely receding" and as it is "pirouetting upon itself, will rapidly, deceptively fade" (Sp 134). Thus, she inverts Lacan's meaning of the mirror reflection to show how woman is not necessarily man's reflection as his other. In fact, man's image disintegrates in the concavity of woman's sexuality.

Irigaray asks: "But what if the 'object' started to speak?" For centuries women have been in "silent allegiance" with the subject, who has established the norms and caused woman's reflection of his sameness, thus excluding all difference (Sp 135). If the other does not participate in reflecting the same's image, the possibilities of what the image
will be are infinite. Irigaray’s interpretation of woman’s body as having the qualities of fluid is particularly pertinent. Only if fluid is perfectly still will a reflection be seen. Since Irigaray emphasizes the movement of woman’s body as representing its dynamic qualities, the quality of fluid associated with woman would not be still to allow a reflection, but would be flowing and would distort an image. Therefore, resistance to remaining a mirror image could result in a difference that is uncontained and overflowing with possibilities for growth.

Mimesis is Irigaray’s method for resisting the pressure to reflect masculine discourse. She uses her text to confound the masculine discourse by examining the words of those who would eliminate the female voice from the text or by expressing woman’s voice in a masculine discourse. In this manner sexual difference can be used subversively by providing a new feminine interpretation. Irigaray’s use of mimesis underscores a definition of sexual difference "as an unrest, which must be taken up and furthered" (Kozel 1996, 120). Not only can sexual difference be described as those biological differences between man and woman, but also as something that can only be understood in the "engagement between self and other" (120). Sexual difference involves not only the interpretation of the unique sexual qualities of each sex, but also how those qualities affect the experiences in the world and with each other. Irigaray describes how we are able to recognize feminine and masculine discourses that emerge in the intersection between self and other where sexual difference is its most profound.
According to Irigaray, both sexes must develop the abilities to recognize each other's possibilities and creativity. This recognition of the other is problematic since the meeting of the subject and object has traditionally occurred within the realm of masculine discourse. If the subject and object begin to recognize each other, new meanings and new discourses would arise. As Irigaray states, "the issue is not one of elaborating a new theory of which woman would be the subject or the object, but of jamming the theoretical machinery itself" (TS 78). Her methods of mimesis and the use of words with multiple meanings place the masculine discourse in a position of not being able to recognize or define all of the images that Irigaray bases on woman’s body

Feminine Imaginary

Irigaray not only reveals the limitations invoked by a masculine discourse, but she also seeks to discover how a feminine discourse can be uncovered. She proposes that before a feminine discourse can be described, a feminine imaginary must emerge without being mediated by a male voice. I will first discuss Irigaray’s description of a feminine imaginary and its place in the unconscious and pre-discursive realm. This will include a discussion of Irigaray’s understanding of the visible and the invisible. Also to better understand how sexual difference plays a part in the feminine discourse, I will explain how her critique of Merleau-Ponty’s and Lacan’s prioritization of sight over touch relates to discourse being representative of only one sex. Finally, I will describe how Irigaray relates the feminine imaginary to a feminine discourse.
The Imaginary, the Unconscious, and the Invisible

Irigaray differentiates the imaginary from discourse as follows: the imaginary involves what occurs in the mind pre-discursively while discourse entails how persons in society communicate. Because the imaginary precedes discourse since it occurs prior to the expression of language, the imaginary must be addressed prior to the symbolic. Irigaray calls the female imaginary "that repressed entity" (TS 28) as that which has not been acknowledged as having value by a masculine discourse. She claims that the feminine imaginary is repressed in a similar manner as Freud represses female sexuality by referring to it as a deficit. Irigaray compares the devaluation of the feminine imaginary with Freud's description of female sexuality. She claims that woman has not been allowed to have her own unconscious unless it is mediated through the masculine discourse and often through male analysts. She says that masculine discourse has positioned woman as "the other side of the sex that alone holds a monopoly on value: the male sex" (TS 69). Irigaray explains that Freud's texts have led to the manipulation of woman's unconscious because of Freud's insistence that woman is only partial and is unable to desire pleasure. She explains that in the language established by the "father," woman is "resubmitting herself to the established order" and "prostitutes the unconscious itself to the ever present projects and projections of masculine consciousness" (Sp 141). She uses Freud's explanation of the Oedipal complex, which is his description of how woman comes to terms with her own and her mother's castrated penis, the clitoris, to explain how woman has been traditionally placed in a passive role. Freud has described how this recognition of the incompleteness of women can lead to melancholia and
hysteria, which he says are psychological problems common to women. According to Irigaray, Freud claimed that a little girl became a woman when

she appropriated in her turn the instrument of sexual pleasure, and possessed—whether by imitation, replica, or duplication—the sex organ that seems to hold the monopoly on sexual use as well as the power to determine the value of sexual exchange (Sp 72-73).

Therefore, woman’s sexual development occurs by way of the penis or some substitute for it. According to Freud, she must find sexual fulfillment through the male sex organ because her own sex organs are not sufficient. Similarly, Freud’s interpretations of the unconscious result in the elimination of value for both woman’s sexuality and voice. This devaluation of woman’s sexuality is what Irigaray is working to overcome, especially as it has been used as a means of interpretation of woman’s unconscious by masculine discourse and male analysts. The unconscious realm is where woman must first find her essence in order to be able to express it in discourse.

Because woman’s development has been interpreted as secondary to that of man’s, even her "self-consciousness would be mediated exclusively or predominantly by a masculine paradigm" (Schutte 1991, 66). Due to woman’s imaginary being constantly repressed and woman recognizing herself only as the mirror image of man, woman has grown unconsciously incapable of recognizing and expressing her own imaginary. In his
description of woman as mirror reflection of man, Lacan also claims that "woman has no unconscious except the one man gives her" (TS 93-94). Irigaray says that Lacan places the father as the giver of law and there is "for women, no possible law for their pleasure" (TS 95). There is only absence for woman who has been analyzed and interpreted historically by men and by the masculine discourse. Therefore, according to Irigaray, the only way that woman can reclaim sexual pleasure and an understanding of the value of sexual difference is by accessing the unconscious, which is a "potential reservoir of feminine energy" (Schutte 1991, 66). Since the imaginary is in the pre-discursive realm, Irigaray must find a way to recognize and describe it. However, Lacan claims that there is no "prediscursive reality...[and] what poses problems in reality turns out to be justified by a logic that has already ordered reality as such" (TS 88). Irigaray points out that woman is then caught in "the circularity of this law" in which she has already been defined by a masculine discourse. Therefore, Irigaray must find a way to uncover a feminine imaginary in the pre-discursive realm in a way to counter Lacan's denial of its existence. Irigaray's discussion of a feminine imaginary includes the importance of making the invisible realm of the unconscious visible so that it can be recognized and valued. If the female object begins to speak from within her own imaginary, she may not be understood because the reference for the male subject is a different symbolic and imaginary. However, if the feminine imaginary continues to be exerted, perhaps gradually it may become recognizable.

Irigaray uses the work of Merleau-Ponty to explain why it has been difficult for the
invisible unconscious of the female to emerge into the visible discourse. Irigaray begins her discussion of Merleau-Ponty’s phenomenological work on a positive note, as she agrees with his explanation of the importance of accessing the pre-discursive realm for a feminine discourse to emerge. Irigaray utilizes his phenomenological approach of positioning consciousness in the lived body, but she criticizes his claims that the visible and the invisible are reversible. His description of reversibility would promote a closure of language that would privilege the discourse of masculine subjectivity because masculine discourse is derived from the priority given to the same, or the image and reflection of the male image. Her critique of Merleau-Ponty’s work is useful in understanding how Irigaray concludes that the discourse of society is closed to new meanings, especially those of sexual difference.

One of the major problems with Merleau-Ponty’s work for Irigaray begins with his privileging of sight over touch. She interprets his emphasis on sight as an elimination of the invisible because he associates the tangible with vision. However, because Merleau-Ponty includes touch as an aspect of vision\textsuperscript{28}, Irigaray says:

\begin{quote}
His analysis of vision becomes even more detailed, more beautiful, as it accords him the privilege over the other senses, as it takes back a great deal of the phenomenology of the tactile (E 175).
\end{quote}

Irigaray continues to be critical of his placing vision as prior to touch. She argues that
touch is the primordial sense and sight requires touch but that touch does not require sight (Vasseleu 1998, 67). By placing the visible in a reversible relationship with the seer, Merleau-Ponty erects a closed system. Irigaray describes how his situating of the visible and the invisible "neglects the sensible medium" (E 162). She says that we sense many things that we do not see, such as "the prenatal sojourn which is always invisible" (E 165). In order to allow a space to detect what "always sing[s] 'behind' words," Irigaray objects to Merleau-Ponty’s claim that the tangible and sight are reversible, and thus do not allow openings for meanings other than those previously established (E, 167). She interprets Merleau-Ponty’s description of vision as totalizing and enclosing, as it "finishes me in relation to the other" (E 174). Thus vision closes the circuit between the invisible and the visible and represents a circularity of speech patterns involving "monosexual" discourse that resists change and represents speech that is "rooted in what has already been said and closes up the circularity between the subject and his speech" (E 177). Therefore, according to Irigaray vision results in sexual indifference because speech reflects masculine subjectivity. Irigaray argues that the sense of touch can communicate sexual difference and is necessary for a feminine imaginary to be uncovered.

Lacan also privileges sight over touch when he places woman as the mirror image of man. He uses the mirror-stage as a "visual metaphor" to describe the development of the ego. Irigaray argues against this "specular drama" as it continues to reinforce only the face of the masculine subject as a reflection through vision, thus denigrating the value
of woman's experience. Even when woman's interior is inspected by "man's eye--understood as substitute for the penis," man still is unable to see her desire (Sp 145). She is referring to the use of a speculum as an instrument that has no interpretive function and assists in objectifying the female body through a visual examination. Instead of looking, she says that woman finds her pleasure in touching. She says:

> Within this logic, the predominance of the visual, and of the discrimination and individualization of form, is particularly foreign to female eroticism. Woman takes pleasure more from touching than from looking, and her entry into a dominant scopic economy signifies, again, her consignment to passivity" (TS 25-26).

Irigaray uses sexual difference to challenge the privileging of sight, and associates touch more with woman's experience. She uses many images of woman, such as her multiple sites of sexual pleasure, her multiple sets of lips which are not closed but touching, and woman's mucous or fluid with its mediating qualities. Irigaray states that touch provides an opening for new meanings rather than closing the system in a visual reversibility. Therefore, Irigaray's interpretation of the unique qualities of woman that represent movement and touching is used as a means to open and recognize a female imaginary that has been closed off by the gaze of man.
The Feminine Imaginary at the Margins

Irigaray claims that women experience sexuality in a decentralized or multiple fashion, that is different from the experience of men. As a phallic society has been created, woman has lost her sense of femaleness. Woman has lost her ability to recognize her own imaginary that is associated with the multiplicity of her sexual difference, and she has accepted a masculine discourse as her own. But woman has been able to escape that discourse at times. In order for the invisible imaginary to emerge from the discourse imposed on her by the gaze of man, woman must disrupt totalizing reflection, thus "leaving open the possibility of a different language" (TS 80). As Irigaray demonstrates with her own writing, when discourse includes multiplicity and avoids the singular meanings of a masculine discourse, it is difficult to recognize as familiar and is relegated to the margins since it does not conform to the dominant and traditional form of discourse.

Although Freud and Lacan insist that woman has nothing to say about sexual pleasure, Irigaray says that women do express pleasure, often "in masquerades" (TS 133). As women try to conform to the descriptions of female sexuality provided by masculine discourse, they have assumed some of what the masculine discourse has determined is normal, even if they are participating in a masquerade. These masquerades are indecipherable by the masculine discourse because, similar to mimesis, woman uses the dominant discourse; but different from mimesis, masquerading places woman at risk of remaining within the sphere of the masculine. When women masquerade, they may be
trying to retain a position within the dominant discourse, but they are also placing their actual feminine sexuality or desire, as understood through a feminine discourse, further toward the margins. She says:

Psychoanalysts say that masquerading corresponds to woman's desire. That seems wrong to me. I think the masquerade has to be understood as what women do in order to recuperate some element of desire, to participate in man's desire, but at the price of renouncing their own" (TS 133).

Woman attempts to express her desire, but she has traditionally only been able to do so by using the masculine discourse. Irigaray says that in order to recognize woman's desire, we must look at "what resists or subsists 'beyond.'" Because it is difficult to find woman's desire expressed unmediated through the masculine, we may begin to access it by looking on the margins of discourse, to what does not completely conform to what a masculine discourse says. Woman's imaginary may escape the masculine gaze as it emerges in a form different from that accepted by the masculine discourse.

Feminine desire has been relegated to the margins, as a residue. It is what escapes being completely dominated by masculine discourse. It may strike a note of recognition although it may not appear within the traditional framework of what has been considered the norm for women. Irigaray describes a feminine imaginary as only being recognizable if we look beyond the masculine discourse or as a supplement to it. Irigaray recognizes
that this devaluation of the feminine is related to a female sexuality that is considered secondary or derivative to male sexuality. Irigaray relates the marginalization of woman and the imaginary in the following:

Must this multiplicity of female desire and female language be understood as shards, scattered remnants of a violated sexuality? A sexuality denied? The question has no simple answer. The rejection, the exclusion of a female imaginary certainly puts woman in the position of experiencing herself only fragmentarily, in the little-structured margins of a dominant ideology, as waste, or excess, what is left of a mirror invested by the (masculine) ‘subject’ to reflect himself, to copy himself (TS 30).

Irigaray finds these pieces of woman’s desire in the unexpected crevices of discourse. She works to disrupt "linear reading" in order to "cast phallocentrism, phallocratism, loose from its moorings" so that the feminine imaginary can emerge from the opening left by the rupture (TS 80). Rather than recommending a new theory of feminine subjectivity, Irigaray describes a process of disrupting the dichotomy of subject and object by a recognition of the excess of the feminine imaginary in its fluid and multiple style.

The Disruption of the Masculine Subject

Irigaray explains that "[w]e haven’t been taught, nor allowed, to express multiplicity"
Because we are socialized with masculine discourse and become accustomed to its sound and uses, multiplicity does not become a part of the traditional discourse. Therefore, we must be aware of those silences and excesses that may be in the pre-discursive realm in which multiplicity may reside. Irigaray celebrates woman's difference in being undifferentiated, formless, and creative by associating it with sexual pleasure of multiple origins. She proposes the unveiling of the feminine imaginary to allow for a fuller development of discourse that would resonate more fully with both genders. The female imaginary is overflowing with creative possibilities because it is not limited within the phallocentric boundaries of masculine discourse. This creativity may be one of the reasons that Irigaray's work may at first seem to be inaccessible. Her ability to recognize and express a feminine imaginary places her discourse outside, or on the margins, of the usual and recognizable masculine discourse.

Irigaray attempts to uncover the repressed feminine imaginary without attempting to substitute it for the masculine. She explains how the feminine imaginary has been obscured in the following:

I am trying, as I have already indicated, to go back through the masculine imaginary, to interpret the way it has reduced us to silence, to muteness or mimicry, and I am attempting, from that starting-point and at the same time, to (re)discover a possible space for the feminine imaginary (TS 164).
In order to upset the current philosophical tradition, she must move beyond phallocentrism toward the acknowledgment of sexual difference. Because the qualities of woman that she emphasizes are associated with openness and multiplicity, she does not want to establish a theory that would become reified and thus be inflexible. She says that:

To claim that the feminine can be expressed in the form of a concept is to allow oneself to be caught up again in a system of ‘masculine’ representations, in which women are trapped in a system of meaning which serves the auto-affection of the (masculine) subject (TS 122).

Irigaray does not describe what a feminine imaginary entails nor does she provide distinct guidelines for recognizing it. Her approach is based on expanding the possibilities of how we think. If she attempted to circumscribe a feminine imaginary she would become entrapped by the boundaries that she is trying to escape. Although she does not explicitly provide a method to access a feminine imaginary, her writing, especially her use of mimesis, provides an example of how to express the feminine imaginary in discourse. In order to read Irigaray’s work, one must think beyond the traditional categories to be able to recognize her use of multiple meanings of words, such as speculum and lips. She uses unusual syntax and grammar to move us outside of our limited use of language that has been molded within a phallocentric world. Irigaray’s work provides a new way to think about how an interpretation of our bodies can initiate
new ways of imagining and thinking in terms of multiplicity and intermediacy.

Feminine Discourse

Difficulties in Establishing Feminine Discourse

The problem for Irigaray is how to express a feminine imaginary when the traditional masculine discourse does not acknowledge it or have a way to express it. I return to gendered discourse now to discuss how Irigaray’s work on sexual difference and the feminine imaginary can be used to reveal a feminine discourse. To accomplish the transition from the unconscious into a symbolic system using images of the female body, Irigaray proposes that one first must be able to recognize a female imaginary and then be able to translate it into a feminine discourse by using sexual difference as a basis. Finding a method to express a feminine imaginary without using a masculine discourse is imperative to Irigaray because the unconscious is already a field of interpretation by man, and woman’s imaginary has remained within the phallocentric order. Since masculine discourse is such a pervasive force within society, those who cannot recognize the overwhelming impact of masculine discourse on our culture are likely to be its victims. Since both genders use masculine discourse unconsciously, women and men continue to reinforce the dominance of a discourse that represents only one gender. Society has traditionally used a masculine discourse without recognition of its basis in phallocentrism, and Irigaray’s work can be used to sensitize us to the extent to which society has traditionally been influenced by masculine discourse. Earlier I described
how language has become inundated by this masculine symbolic system and how it has been considered neutral, thus allowing for a continuation of the same masculine discourse without recognition or question. Irigaray’s work helps us recognize the dangers involved in not questioning the accepted discourse of society. By using her work based on the feminine imaginary, we can become aware of a dissonance between the traditional discourse and personal experience that is particularly evident in health care.

In order to make a change in discourse, Irigaray realizes that she must be understood, and therefore she admits that her writing utilizes the system already used by society even though it is steeped in masculine symbolics. While Irigaray strives to make a feminine imaginary recognizable, she must work within the current language available. She says:

I am obliged, compelled, to go back to the most commonly spoken form of discourse. I am trying to circumvent this discourse trying to show that it may have an irreducible exterior. But in order to do so, it is true that I have to begin by using standard language, the dominant language (TS 144).

Her writing avoids using language and grammatical constructions, such as metaphors, that reinforce a masculine discourse because "[a] metaphor completes her" because by her nature, woman is incomplete and in a state of flux (Sp 229)\textsuperscript{33}. Her critique of the use of metaphor shares some of Nietzsche’s concerns\textsuperscript{34}. Nietzsche claims that metaphor "is not merely a linguistic entity, but rather a process by which we encounter the world"
(Johnson 1981, 15). According to Nietzsche, there is little literal meaning of language because it is the result of multiple transitions between perception of an image, which can vary among persons, and a concept. Therefore, Nietzsche says:

What therefore is truth? A mobile army of metaphors, metonymies, anthropomorphisms: in short a sum of human relations which become poetically and rhetorically intensified, metamorphosed, adorned, and after long usage seem to a nation fixed, canonic and binding; truths are illusions of which one has forgotten that they are illusions; worn-out metaphors which have become powerless to affect the senses...(1974, 180).

While Irigaray does not claim that there are no literal meanings in language, she stresses that different experiences with the world result in multiple interpretations. She is concerned about the traditionally accepted meanings, rather than literal meanings, that have been promulgated through masculine discourse. Irigaray argues that language should be understood as having multiple meanings, especially due to the various interpretations based on our sexual differences. It is important to Irigaray that our language not allow metaphors to create a closed system around "literal" or traditional meanings that may not have meaning for those who encounter the world differently.

If Irigaray totally refused to use masculine discourse, she would need to develop a new means of communication; however, she seems to have chosen a practical means to
discuss feminine discourse in terms that could be understood by both genders. However, her work includes aspects of a discourse that are not common and involves a multiplicity of meanings. Her method of mimesis places her writing on the margins of a traditional discourse where she can find crevices from which to cause a disturbance.

**Recognizing a Feminine Discourse**

How woman discovers her voice in a world dominated by masculine symbolics that consciously or unconsciously represses feminine discourse is a problem that affects all of humanity. Both genders are deprived of a different and dynamic discourse when a feminine discourse remains unrecognized. Irigaray’s discussion of sexual difference involves interpreting certain distinct qualities of the female body that provide the basis for a feminine discourse. She does not say that only women can have qualities of multiplicity, openness, and intermediacy, but that these are qualities of the female body that have been overlooked and have not been discussed in terms of their importance or possibility. Rather than placing the sexes in opposition or in a hierarchy, Irigaray celebrates the differences in the qualities of man and woman, and she recognizes the potential for growth that can arise from within difference rather than sameness. If woman is considered the mirror image of the subject, she is limited and enclosed by the boundaries of the reflection. However, if she is allowed to speak through her own imaginary, a discourse different from the masculine one can arise\(^{35}\). Irigaray does not promote a separation of the genders, but rather an interchange that can only occur between subjects speaking from their own selves. The qualities of feminine discourse
allow for multiple interpretations and dynamic interactions that promote a sense of
growth and becoming within the discourse. It is important for both genders to
recognize the creative aspects of a discourse that allows sexual difference to be
acknowledged as a part of it.

Irigaray discusses feminine discourse in terms of woman’s experience in the world. She
does not focus on the experiences of the individual woman, rather on women as a group
because "[a] long history has put all women in the same sexual, social, and cultural
condition. Whatever inequalities may exist among women, they all undergo..." (TS
164). Since women’s voices have been silenced by masculine discourse, Irigaray says
that "it is very important for women to be able to join together" (TS 164). She claims
that women, whether consciously or unconsciously, share the same experiences of having
had their voices and imaginary repressed by masculine discourse. Irigaray acknowledges
that her work is political, and if women want to "escape from exploitation," they must
"challenge the very foundation of our social and cultural order" (TS 165). Like many
feminists, Irigaray is not satisfied to discuss potential cultural changes, but wants to
promote actual change in language and society. She uses sexual difference to explain
how women share many of the same experiences in society that have traditionally been
described by use of masculine discourse.

While both individual and group experiences are important aspects of women’s discourse,
Irigaray cautions that we must discover a way in which to discuss woman without it
being "understood as, a recuperation of the feminine within a logic that maintains it in repression, censorship, nonrecognition" (TS 78). Her concern is that woman's experiences have often been described through a man's eyes and as a reflection of man's experiences. Therefore we must find a way to discuss women's experiences without falling victim to a masculine discourse. When interpreting experience, the influences of a traditional masculine discourse must become part of our conscious awareness. Care must be taken with "[t]hose things that are not said or said between the lines since they have already been given meaning" (Sp 235). It is Irigaray's intention to disrupt those aspects of discourse that do not include woman and yet continue to be used as if they are universally applicable.

Instead of proposing a new language for women, Irigaray attempts to change our perception and understanding of how masculine symbolics have influenced us consciously and unconsciously. She encourages a conscious effort to be aware of signals, received through silences or gaps, and to be prepared to respond with an effort to overcome the trappings of masculine discourse. Through an appreciation of sexual difference and the qualities of woman such as openness, nearness, and intermediacy, we should become aware of subtle signals in discourse. Irigaray does not provide us with a formula for a feminine discourse, but she says:

And if you find yourselves attracted by something other than what their laws, rules, and rituals prescribe, realize that - perhaps - you have come across your
‘nature’ (TS 203).

Expressing a feminine imaginary is difficult because we have "become accustomed to obvious ‘truths’ that actually hide what she is seeking" (Sp 193). Woman must be able to see outside of her own boundaries that have been established in the reflection of male sameness. A feminine discourse reflects the qualities of women and their experiences through images of women being in excess and overflowing that cannot be contained within boundaries. Irigaray explains that sometimes it is only through sensing that "something remains to be said" that woman may be able to begin to express herself. It is in the remainder or the excess of that which has been devalued for so long, that woman may begin to recognize her imaginary and express it. Irigaray recognizes the difficulty of her proposal in the following:

And if, by chance, you were to have the impression of not having yet understood everything, then perhaps you would do well to leave your ears half-open for what is in such close contact with itself that it confounds your discretion (TS 119).

Irigaray understands that to hear a feminine discourse one must be sensitive to what is different. It may be a voice that sounds out of harmony with the usual discourse, yet it may sound familiar.
One of her methods to escape a discourse of sameness and to reflect a discourse as overflowing its boundaries is to use words and expressions with multiple meanings and interpretations. Because of the multiplicity inherent in her writing, Irigaray has not always been satisfied with the translations of her work. It may seem contradictory for Irigaray who encourages multiple meanings and interpretations, to be critical of others’ translations. However, her critique stems from her work having been narrowly delimited by her translators, rather than capturing the fullness of her intended meanings. For example, she has expressed dissatisfaction with the title *Speculum of the Other Woman* because it appears to refer to two women and does not reflect the multiplicity implicit in her interpretation of women and otherness. In an interview she says, "What I myself say is that there is no true Other in Western culture and that what I want - certainly I don’t want to be second - but I want there to be two subjects" (Hirsh and Olson 1995, 99). She is not referring to an other, but to the possibilities of objects becoming subjects through a discourse grounded in sexual difference.

Irigaray chooses words and grammar that are reflective of sexual difference, that is, they are fluid and open. Her writing embodies a sense of openness based on the use of words and grammar that can be variously interpreted. Like the lips she describes, her writing conveys a nearness so that it becomes the intermediary in converting feminine imaginary into discourse. It has a familiar, yet strange, sound to it and promotes an engagement with her feminine discourse of difference. Through her writing, a feminine imaginary is released that avoids using or reflecting a univocal masculine discourse.
It is important not only to recognize how pervasive masculine discourse is, but also to be able to perceive when the feminine imaginary and voice are trying to emerge from the crevices. Irigaray looks for spaces or gaps in traditional discourse, and she seeks remnants of feminine discourse in those places of silence\textsuperscript{37}. I will show how remnants of a feminine discourse are buried within the dominant discourse where it is often unseen or devalued, and how woman's voice can be excavated so that it can be expressed through the feminine, not solely via the masculine.

**The Example of Mystic Language**

Irigaray advises that a new discourse may sound unfamiliar in its creativity and openness. Mysticism and hysteria are two of Irigaray's examples of the expression of feminine imaginary. Irigaray says that woman "functions as a hole" that "inevitably affords woman too few figurations, images, or representations by which to represent herself," and therefore "\textit{Hysteria is all she has left}" (Sp 71). Her psychoanalytical interpretation of hysteria is important in understanding Freud's theory of woman's development and its impact on feminine discourse. Earlier I discussed her interpretation of Freud's description of hysteria as a response to woman's becoming aware that she is deficient. However, I will now turn to her writing on mysticism since it provides an example of what Irigaray means when she discusses a feminine discourse.

Within the circularity of phallocentric sameness that is established by the subject and the reflection of the object, Irigaray looks for a rupture to allow a feminine discourse to
escape. Irigaray describes how the "‘soul’ escapes outside herself, opening up a crack in the cave (une antr’ouverture) so that she may penetrate herself once more" (Sp 192). Irigaray uses mystic language as an example of how woman has broken the walls that imprison her unconscious\textsuperscript{38}. She says:

This is the place where consciousness is no longer master...This is the place where ‘she’ - and in some cases he, if he follows ‘her’ lead speaks...about contempt for form as such, about mistrust for understanding as an obstacle along the path of jouissance and mistrust for the dry desolation of reason (Sp 191).

Mystic language is used to describe how feminine imaginary that resides in the pre-discursive unconscious is transcribed into a symbolic system. Although mystic language is not the discourse of health care or found in society at large, Irigaray’s discussion of mystic language can be viewed as an example of a feminine imaginary that has emerged into a discourse that was not always recognizable. Because mystic language was used by both male and female mystics and saints, there is evidence that both genders are capable of understanding and using a discourse that incorporates feminine imaginary\textsuperscript{39}.

According to Michel de Certeau, mystic language involves the return of the "ghost of the One" (1992, 4)\textsuperscript{40}. Irigaray appreciates the significant impact of mystic language in a similar way that de Certeau does, who says:
From the certainty of the divine Interlocutor whose language is the cosmos to the verifiability of the propositions that made up the content of revelation, from the priority of the Book over the body to the (ontological) supremacy of an order of beings over a law of desire, there was not one postulate of this medieval world that was not touched or undermined by the radicalism of these mystics (7).

Both Irigaray and de Certeau recognize mystic language’s capability of accessing the imaginary outside of masculine discourse. Irigaray says that when women have attempted to express a different understanding of their relation with the world or the divine, they "were accused of being witches, or mystics...women could have only a forbidden Other of their own" (E 114-115). In order to reach those recesses of the unconscious, invisible to the gaze of the masculine subject, the language of mystics was expressed "still in darkness to herself" and mediated through her body; "Always without consciousness" (Sp 198-199). The discourse of the mystics arose from the darkness of their unconscious where the male eye could not pierce and specularize. In various manifestations, the mystics spoke through their bodies and with "a touch that opens the ‘soul’ again to contact with the divine force" (Sp 193). St. Teresa of Avila is an example of how her body was touched by a commandment to write. Although she suffered physically, her writing opened a space for the "mark of the other, the wound of his passage" (de Certeau 1992 198). De Certeau describes how St. Teresa’s bodily suffering and her written text were done "for them [pour eux, masculine]. But the spoken word, a collective circulation, is between them [entre elles, feminine]; between us"
(1992, 193). This is related to Irigaray's argument that a masculine discourse is imposed on us, but feminine discourse is similar to what de Certeau calls "the abundant and 'indistinct' speech that crosses over individual or scriptorial boundaries; it doubtless carries an implicit reference to the intensification of a feminine experience..." (1992, 193). St. Teresa's bodily experience opened the space for the mystical language that is "the establishment of a space where change serves as a foundation" (de Certeau 1986, 100). Irigaray recognizes that the language of the mystics is generated in that space of bodily experience and can be used to disrupt the masculine subjectivity of indifference. Sexual difference provides that space or rupture for the feminine imaginary to emerge.

As I have discussed above, Irigaray's description of sexual difference is based on qualities of the female body that can be interpreted and used figuratively in discourse. In her examination of the female body she finds specific qualities that are unique to woman's experience, but when associated with discourse, these qualities could be recognized and celebrated by anyone who is sensitive and open to hearing a new discourse. Irigaray does not describe a specific feminine symbolic system that may arise from a feminine imaginary, because to do so would enclose an imaginary that she wants to be fluid and uncontainable.
The Sensible Transcendental

Overcoming oppositions

Irigaray's description of the divine serves as another example of a feminine discourse grounded in sexual difference. Her descriptions and expressions of God shed light on how Irigaray envisions a feminine imaginary being expressed within the current symbolic system, but influenced by feminine discourse. Irigaray reminds us that religious language, like that used throughout society, is based on masculine discourse. In the position as "Other," "God functions as the keystone of language, of sign and symbol systems" (E 112). As such, the traditional language associated with God fixes God as the "transcendent that ensures and guards the whole world entity" (E 112). "He" has been elevated to a position of authority above the world separated from humans.

Irigaray, however, expresses God as dynamic, using descriptors with the same qualities of woman, such as fluid, mobile, and in the process of becoming or intermediacy. She describes how masculine discourse places God as solely transcendent, and that this Other "has for centuries been scrupulously protected by the word of men" (E 112). This image of God places "Him" apart from the sensible world of human beings. She provides a different interpretation of how we might understand God if we consider how woman's body can be used to derive new ways of discourse. In an effort to overcome the opposition of transcendence and immanence, her interpretation focuses on using images based on flexibility, dynamic interpretation, and open-endedness, rather than those of stability, closure, or a static interpretation. Irigaray has provided new tools for us to use
when interpreting the world through eyes opened to sexual difference that value the qualities of both genders.

The incarnation of God in Jesus is of particular importance for women, according to Irigaray. Irigaray does not acknowledge those theologians who suggest "Christologies, interpreting the two natures in the one perfect person" (Ward 1996, 230). She claims that a male discourse has led us to think of God as "an inaccessible transcendence" with "representations that are still extrapolated from the body" (E 148). Irigaray says that God traditionally has been placed as transcendent, with His male son taking the incarnated form. Her work emphasizes the overcoming of the dichotomy of immanence and transcendence and is unique in its association of the incarnation of Jesus with the experience of women. Irigaray emphasizes the importance of the embodiment of God, as it allows God to be accessible to humans. When the traditional transcendent masculine version of the divinity is accepted, the closeness of God in the here and now may be missed, and only a "Father-son duality" may be recognized.

Irigaray overcomes this duality by "employing ‘Jesus’ and ‘Christ’ in a way that blurs the distinction between the historical male and the symbolic representation of this male" (Ward 1996, 228). She explains that the transcendent and immanent Jesus Christ are created in a space created by the wound of the nails and the spear. Irigaray relates the image of a wound or slit, which is also found in mystical writing, to woman’s two sets of lips. She says: the "abyss opens down into my own self, and I am no longer cut in
two opposing directions" (Sp 200). From this opening where "the Word was made flesh," woman's joy overflows and she becomes transcendent while fully embodied. This is in opposition to Beauvoir who argued that only man had the capability to be transcendent. In this space woman's imaginary finds its voice as that which is always expressed as something more than just the reflection of the same. Irigaray uses the lips as a symbol of this intersection between immanence and transcendence that then eliminates oppositions and promotes fecundity. She says:

(Two sets of lips that, moreover, cross over each other like the arms of the cross, the prototype of the crossroads between. The mouth lips and the genital lips do not point in the same direction... (E 18).

She is interpreting the female body as having both a horizontal and a vertical dimension that represents immanence and transcendence. Discourse and sexual difference coincide in the symbol of the cross to allow the emergence of transcendence and immanence through the love of Jesus Christ. Irigaray says that love allows woman the "ability to perceive the divine" (E 115) and to overcome the opposition between transcendence and immanence.

In order to appreciate Irigaray's description of God, we must "attain an intuition of the infinite." This is a key point in Irigaray's presentation of the divine because instead of only being able to see things in finite and fixed terms, we must be able to see beyond,
to what "remains unfinished and open to a becoming" (E 111-112). It involves thinking creatively and using our imaginary as it emerges from Irigaray's description of woman's body as being open and dynamic. Irigaray announces the death of God, but differently from Nietzsche. She claims that the God whose death to which she is referring is one who forms the transcendental keystone of a discourse used by a single gender, of a monosexed truth. And this would allow the return of the divine, of the god who preaches neither truth nor morality but would seek to live with us and allow us to live here (E 140).

Irigaray sees a new era, post Father and Son, in which the spirit is incarnated as a mediator both vertically and horizontally, as a sensible transcendental. She emphasizes that God is among us and reflective of us, incarnated in each person. Both genders should be capable of recognizing a new discourse if the unique qualities of the female body are interpreted via sexual difference. She says that a masculine interpretation traditionally has placed God up above, safely established as the Other, yet a feminine discourse promotes an ongoing relationship with God. This relationship is similar to the mystic's embodied relationship with the divine through the unconscious that serves to overcome the dichotomy between man's transcendence and woman's immanence. In order to understand this, we must be able to imagine the infinite.
Sexual difference as mediation

Irigaray interprets the qualities of woman that make her sexually different as allowing a mediation between the world and the divine because they have the capabilities to eliminate boundaries that have kept us from knowing God's presence. She explains how an understanding of women's bodies and sexuality as uncontained and dynamic prepare women to recognize the infinite and the divine. She speaks of a "right to their own spiritual becoming, a right in harmony with their sexed body instead of one that denies it in the name of an allegedly universal and neutral truth" (Je 94). When a woman recognizes that her body's experience in the world is different than what she has been taught, a feminine imaginary can begin to emerge from the crevice that is created by this dissonance. Irigaray is seeking a "harmony" that would then allow access not only to the feminine imaginary but also to the divine. While woman has the capability to be a mediator, based on her sexuality, she must be able to reveal her imaginary in order to emerge from the masculine discourse that has kept her from being responsive to the divine in the world. Irigaray provides an interesting example of how the divine can be opened to our senses. She says that "angels would circulate as mediators" (E 15). As messengers, angels reveal the universe to us as they move between the envelope of God and that of the world...Irreducible to philosophy, theology, morality, angels appear as the messengers of ethics evoked by art - sculpture, painting, or music - without its being possible to say anything more than the gesture that represents them (E 16).
Irigaray is describing how she sees a feminine imaginary being transformed into a symbolics, using the analogy of angels as mediators who transform our unconscious into the conscious. Irigaray’s description of the transition from the imaginary to the symbolic system is unusual and difficult to understand at times, but it provides a place where there is opportunity for the emergence of the feminine voice. Part of the difficulty is due to the masculine discourse erecting barriers to a recognition of a feminine imaginary being able to be expressed in its fullness. There seems to be room for creativity and fecundity at this intersection of the unconscious and the conscious. Angels may not be the mediators in health care, but a feminine discourse grounded in sexual difference should promote the emergence of an intermediary who could circulate as messenger of the divine.

We must look at culture to find the imprint of God to discover ethics. She envisions ethics emerging at the intersection of God and the world, especially as understood through the world of art. If we allow the feminine imaginary that is overflowing with possibility to interact with culture, such as with art and music, a new recognition of the divine in the world could emerge⁴⁵. Because the divine may be ascertained in the sensible world, and the boundaries between the transcendent and the immanent are overcome, we should find our ethical guidance within the context of our own experiences. If woman is unable to think in terms of a feminine imaginary, she may miss "her own call to the divine" (E 196). A feminine discourse would include the recognition of the importance of woman’s experiences and relationships in the world and
would acknowledge the presence of the divine in all aspects of society. Irigaray describes the self as being permeable enough to be open to the influences of history and experience, but closed enough to remain an "I" (E 62). Sexual difference could be used to open new ways of communication rather than reinforcing biological stereotypes that have been detrimental, especially to women. Rather than thinking in terms of hierarchy or opposition, Irigaray's work allows multiple interpretations of situations rather having one rigid and fixed meaning.

In order to have an ethics of gendered intersubjectivity that is grounded in sexual difference, there must be a rupture in the discourse of the traditional masculine subject in its relationship to a fixed feminine object. A feminine discourse grounded in the multiple interpretations of the morphology of the female body would need to emerge from this space opened by difference to subvert the masculine discourse. Irigaray provides us with clues and examples of what a feminine discourse might sound like. Through mimesis she has provided a method to undermine the masculine discourse by entering it and redirecting it internally. In her earlier work she says "It is still better to speak only in riddles, allusions, hints, parables. Even if asked to clarify a few points" (Sp 143). Later she continues her search for ways to express the feminine imaginary in discourse, and perhaps a bit more impatiently, she says:

Let's hurry and invent our own phrases. So that everywhere and always we can continue to embrace. We are so subtle that nothing can stand in our way, nothing
can stop us from reaching each other, even fleetingly, if we can find means of communication that have our density. We shall pass imperceptibly through every barrier, unharmed, to find each other. No one will see a thing...Rather than letting ourselves be subjected to their branding. Rather than being fixed, stabilized, immobilized. Separated (TS 215-216).

Irigaray issues a challenge to find our own voices in our own way. This is a particularly daunting task when applied to the discourse of health care that is so thoroughly steeped in masculine discourse. As Irigaray has shown we can allow sexual difference to open the space and to provide the means for the feminine imaginary to be released and witnessed by all who recognize and celebrate the relationship of the unique qualities of the female body to a feminine discourse.

Summary

Irigaray provides direction in examining traditional discourse, so that the biases imposed on it by masculine discourse can be recognized. Although her work has not been used in connection with the institution of health care, it is relevant to the texts and relationships within this environment due to health care’s highly gendered nature. In earlier chapters I discussed the role of gender in the historical evolution of health care professions as well as the significance of gender in the structural and dynamic components of these interprofessional relationships. Irigaray’s work provides a means whereby the gendered nature of the discourse of health care and its relationships can be
identified. In the next chapter I will further discuss the impact of gendered discourse on the ethical ramifications of interprofessional relationships and also on the quality of care that patients receive.

By associating specific unique qualities of women’s bodies that have been interpreted as multiple, fluid, open, and intermediate, Irigaray celebrates aspects of women that have been overlooked and devalued by a masculine discourse that values sameness and rigidity in its relationship with the world. Irigaray uses this difference based on the phenomenology of the female body to describe a feminine discourse that emerges from a feminine imaginary. In the next chapter I will describe how the institution of health care and its ethical methodologies could reflect these more fluid qualities, especially with respect to traditional health care ethics based on principlism and casuistry. Part of my task will be to show how a health care discourse grounded in sexual difference can be relevant to both genders.

Ethical consideration of dilemmas in health care that incorporate an Irigarayan perspective of sexual difference might include a more varied group of voices. There might be less emphasis on those persons’ viewpoints in positions of authority and more on those in positions of mediation. I will discuss how the inclusion of multiple voices and varied interpretations of circumstances would be an important part in an ethics influenced by Irigaray. Health care relationships among patients and providers include infinite properties and considerations because of the variable context and environments
in dealing with many different patients and family members. In this fluid environment of health care, technology is constantly evolving while at the same time, health care providers must meet the daily needs of patients whose health status frequently changes. Therefore, the environment and the context in which health care is provided is in constant flux. There needs to be a greater appreciation for the dynamic variables that affect all of these relationships that occur within a fluid environment.

One of the concerns that will be addressed in the next chapter is how feminine discourse based on sexual difference can influence a discussion of health care ethics, that has been and continues to be, embedded in such a thoroughly masculine discourse and environment. The qualities of the female body that allow her to be in a state of becoming, fecundity, or intermediacy will also be significant in beginning to transform health care discourse to one that will embrace its uncertainty and recognize the importance of the voices of all of those who care for patients. It will be my goal to show that when multiple voices are heard and the distinction between subject and object is less distinct, that patients will benefit from a discourse more open to multiple interpretations.

NOTES

Chapter Four

1. In an interview with Luce Irigaray by Elizabeth Hirsh and Gary A. Olson, "‘Je - Luce Irigaray’: A Meeting with Luce Irigaray," Hypatia 10 (Spring 1995): 93-114, Luce Irigaray says, "above all don’t say Irigaray, I have a horror of that" (102). Although I
would like to honor her preference to be referred to by her entire name, I will not include her first name each time her name is written due to the accepted methods of academic writing. I recognize the importance of using a writer's first name since that name usually designates gender. Without the use of the first name, the writer's gender becomes unknown. This is an important technique of masculine discourse which neuters the writer, thus not giving recognition to the work of women.

Similar issues regarding the use of names arise in health care, yet from a different perspective. Most nonphysician health care providers are referred to by only their first names while physicians are almost always called "Dr." and the last name. This is an example of how authority is maintained through a traditional discourse generally accepted by the institution of health care.

These are examples of how masculine discourse has inundated our academic and health care institutions and reflect Irigaray's concerns for how difficult it is to change culturally accepted discourse.

2. According to Margaret Whitford in Luce Irigaray: Philosophy in the Feminine (London: Routledge, 1991), it is important to "engage with Irigaray in order to go beyond her" so that a relationship is formed with her work which allows room for growth in the process of reading (6).

3. Later I will discuss her work on the relationship of the subject to the object and how gender plays a major role.

4. Irigaray uses mimesis to engage with writers in a voice which resonates with their own. She uses their words but then undermines them to allow new meanings. In contrast, Plato's description of mimesis is more directly related to imitation, which is seen in Plato's criticism of the poets for only being able to imitate reality. In The Republic he is adamant that poets are not to be admitted into his city, the ideal community. In Gerald F. Else, Plato and Aristotle on Poetry, edited with introduction and notes by Peter Burian (Chapel Hill: The University of North Carolina Press, 1986), Burian describes Plato's historical development in relation to poetry from an early childhood love of poetry to an adult "vehemence of Plato's rejection of poetry" (4).

However, Plato uses mimesis extensively in his writings. In The Symposium he uses the voices of Socrates and Diotima to draw others to his conclusions. According to Arne Melberg, in Theories of mimesis (Cambridge: Cambridge University Press, 1995), Plato uses mimesis in "situating his long-past meeting with Diotima in the present, in the now of the Platonic dialogue" (27).

Irigaray uses mimesis differently from Plato; as a means to undercut a previously determined conclusion. She does not use mimesis to promote presence, but rather she prefers interpretations that are unstable and multiple that encourage a search for new meanings.
5. In "Irigaray's Mimicry and the Problem of Essentialism," Hypatia 10, no. 4 (Fall 1995): 76-89, Ping Xu describes this "double function" as "aggressive mimicry" and "defensive mimicry" (79, 83).

6. In "The Diabolical Strategy of Mimesis: Luce Irigaray's Reading of Maurice Merleau-Ponty," Hypatia vol. 11 (Summer 1996), 114-129, Susan Kozel says that Irigaray's work requires a combination of both a "direct" and an "indirect" reading of her text. Because the discourse of philosophy is grounded in the masculine voice, Kozel points out that if Irigaray attempted a straightforward, or direct, discussion of sexual difference, she would be forced into using the masculine voice of the "Same" which "would prevent us from thinking sexual difference" (119). Kozel's title calling Irigaray's method "diabolical" is descriptive and accurate in its depiction.

7. Serene Jones, in "This God Which Is Not One: Irigaray and Barth on the Divine," in Transfigurations: Theology and the French Feminists eds. C.W. Maggie Kim, Susan M. St. Ville, and Susan M. Simonaitis (Minneapolis: Fortress Press, 1993), 109-141, compares Irigaray's methods to that of a "talmudic storyteller" in which she "reads between the lines of these texts in order to excavate primal scenes, plots, and characters that history has buried and hence centuries of interpreters have missed" (112).

8. In "The Hidden Host: Irigaray and Diotima at Plato's Symposium," in Revaluing French Feminism: Critical Essays on Difference, Agency, and Culture eds. Nancy Fraser and Sandra Lee Bartky (Bloomington: Indiana University Press, 1992), 77-93, Andrea Nye criticizes Irigaray for taking Diotima out of her historical context and applying twentieth century feminist presuppositions to her words, thus seeing Diotima as "a Platonist" (79). Nye describes how a historically religious Greek woman could have appeared as "an authoritative role as the teacher of Socrates" (85). Although Diotima is not physically present, Nye allows Diotima's words to carry the authority of a prophetess. According to Nye, Plato uses Diotima to teach what has been determined as the "correct" conclusion determined in advance... that the "divine source of Beauty becomes the Form of the Good" (89). While Nye may have concerns regarding Irigaray's knowledge of the history and the culture of Greece during Plato's life, both Nye and Irigaray recognize the significance of a woman's voice as being a part of Plato's philosophical writings. Although Nye is critical of Irigaray's interpretation of Diotima's words, they both postulate that Diotima ultimately is describing love in Platonic terms, which is the seeking of immortality through the understanding of love.

9. In Textures of Light: Vision and Touch in Irigaray, Levinas and Merleau-Ponty (London: Routledge, 1998), Cathryn Vasseleu explains how Merleau-Ponty distinguishes the lived body from the physical body. She says that the lived body "is produced within an elaborate system of correspondences that collectively make up a perceptual field, and the latter is an object of biology." Further, the "lived body is a cultural identity produced within the perceptions that dawn through it" (28).
10. In "Phenomenology and the Frontiers of Experience: Merleau-Ponty and Irigaray," *Historical Reflections* 19, no. 1 (1993): 17-33, Eleanor M. Godway discusses how Irigaray's claim of a "generic" masculine pre-predicative is one of the reasons that she has been called an "essentialist" (23). I will discuss these accusations of essentialism later in this chapter.

11. In "Merleau-Ponty and the Phenomenology of Perception," in *Contemporary French Philosophy* ed. A. Phillips Griffiths (Cambridge: Cambridge University Press, 1987), Cyril Barrett states that Merleau-Ponty believed that "the activity of the body" was "fundamental to perception" (129). Barrett quotes Merleau-Ponty as saying that "The perceiving mind is an incarnated mind" (129).

12. For a succinct historical journey through the philosophical precursors of feminism, including the influence of Descartes on Beauvoir and Merleau-Ponty, see the introduction in *The Thinking Muse: Feminism and Modern French Philosophy* eds. Jeffner Allen and Iris Marion Young (Bloomington: Indiana University Press, 1989).

13. In *Textures of Light*, Cathryn Vasseleu says that Merleau-Ponty "emphasizes the simultaneous participation of multiple physiological and psychological factors in the processes of perception" (23). She explains that this is a dynamic process of "creative receptivity rather than a passive capacity to receive impressions" (24).

14. For further elaboration of various interpretation of Irigaray's images see Margaret Whitford's article: "Irigaray's Body Symbolic," *Hypatia* 6 (Fall 1991): 97-110. She provides a brief overview of how these images have been variously described as a "postmodernist reading..., a literal reading..., to combat Lacanian theory..., a symbolization of the imaginary..., a deconstructive concept..., feminist politics" (98-101).

15. In *Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory* (Bloomington: Indiana University Press, 1990), Iris Marion Young's essay the "Breasted Experience" describes women's breasts in terms of fluidity and movement, especially in woman's experience. She says: "For many women breasts are a multiple and fluid zone of deep pleasure quite independent of intercourse, though sometimes not independent of orgasm" (194). She further explains how the breasts can be molded within the boundaries of a bra "that phallic culture posits as the norm." Young says that without a bra women can experience their breasts "more like a fluid than a solid; in movement, they sway, jiggle, bounce, ripple even when the movement is small" (195).

16. In "Difference on Trial: A Critique of the Maternal Metaphor in Cixous, Irigaray, and Kristeva," in *The Thinking Muse: Feminism and Modern French Philosophy*, eds. Jeffner Allen and Iris Marion Young, Domna C. Stanton cautions that if Irigaray uses the maternal to counter patriarchal cultural images, she runs the risk of it becoming the same as a masculine discourse of indifference (170).
17. If differences are attributed to biological factors, then care must be taken not to enhance the patriarchal notions of a hierarchical value system which might value man over woman. Therefore, concerns about essentialism are valid. However, I prefer not to try to categorize Irigaray's methodology as essentialist or otherwise; rather, I want to focus on her ability to look at the female body without using designated categories. In "This God Which Is Not One: Irigaray and Barth on the Divine," Serene Jones recommends that we may need to " bracket the question of essentialism and take a more pragmatic approach to analyzing her project" (121). While Irigaray uses the body and sexual difference to reveal phallocentrism, according to Nancy Fraser in "Introduction: Revaluing French Feminism," in Revaluing French Feminism: Critical Essays on Difference, Agency, and Culture eds. Nancy Fraser and Sandra Lee Bartky (Bloomington: Indiana University Press, 1992), "her project is less to reduce social meanings to biology than to create new, empowering social meanings for our bodies and pleasures" (11).

18. In "Irigaray's Mimicry and the Problem of Essentialism," Hypatia 10 (Fall 1995): 76-89, Ping Xu explains that Irigaray uses essentialism to "reveal the essentialist and 'sexed' nature of the tradition that has the power to reduce everything into its selfsame system, according to Irigaray, one has to 'pass through' essentialism" (85). While this elaborates Irigaray's use of mimesis, Xu claims that Irigaray "is not an essentialist" (87). This seems to be placing too much emphasis on trying to defend Irigaray against efforts to categorize her work as essentialist. Her writing defies categorization, and further Irigaray does not seem to defend a position for or against essentialism.

Diana Fuss, in "Essentially Speaking': Luce Irigaray's Language of Essence," in Revaluing French Feminism: Critical Essays on Difference, Agency, and Culture, edited by Nancy Fraser and Sandra Lee Bartky, 94-112, also discusses how Irigaray uses essentialism "not to imprison women within their bodies but to rescue them from enculturating definitions by men" (67-68). I agree with her assessment of Irigaray's use of essentialism in that "essentialism represents not a trap she falls into but rather a key strategy she puts into play, not a dangerous oversight but rather a lever of displacement" (77).

19. In Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory (Bloomington: Indiana University Press, 1990), Iris Marion Young points out the irony of feminist interest in defending the subject just as "Euro-American male intellectuals should declare the death of the subject" (13). She attempts to find a mediation between postmodernism's rejection of the subject and a need for "a notion of the subject in order to name an awareness of oppression and a starting point of resistance" (13). As I will discuss further, Irigaray does not seek to reverse the traditional subject/object hierarchy, but to unveil a feminine discourse so that women's voices can be recognized.

20. In "Irigaray on the Problem of Subjectivity," Hypatia 6 (Summer 1991): 64-76, Ofelia Schutte uses the term "reinvention of subjectivity" as opposed to "reconceptualize" because "to reconceptualize it, according to Irigaray, would be merely to leave it where
it is today" (72). Irigaray is doing more than just changing the description and use of subjectivity as she appears to be trying to break down the barriers between the subject and the object which have been reinforced by western philosophy and psychoanalysis.

21. In **Lacan** (Cambridge: Harvard University Press, 1991), Malcolm Bowie describes Lacan's account of the child being "captivated" by the image in the mirror. In order for ego development to occur, Lacan says "Man must break the charm of his reflected image by accepting the reality of its unreality" (Bowie 23). The self can only be identified beyond the reflection in the mirror.

However, in **Lacan and Theological Discourse** eds. Edith Wyschogrod, David Crownfield, and Carl A. Raschke (Albany: State University of New York Press, 1989), David H. Fisher says that for Lacan, "the ego is essentially a defense formation, not a nucleus around which a self can be built, and that there is no such thing as a 'total person' or 'total self'; the subject, as already noted, originates in the split between a disjunctive and a unified image of itself" (6). Therefore, Lacan does not recognize "ego strengthening" as a goal of psychoanalysis.

22. In "The Face Before the Mirror-Stage," **Hypatia** 6 (Fall 1991): 140-155, Cathryn Vasseleu discusses how Lacan "describes the imaginary formations of both sexes in terms of the primacy of the 'phallic' gestalt" in which "subjectivity is achieved culturally through mutual recognition of the symmetry of reflection between self and others" (142).

23. In **Lacan** Malcolm Bowie compares Freud's three mental forces of the ego, id, and super-ego with Lacan's "triadic style of thinking" in terms of the three "orders" of the Symbolic, the Imaginary and the Real (90-91). The Imaginary "is the order of mirror-images, identifications and reciprocities....The Imaginary is the scene of a desperate delusional attempt to be and to remain 'what one is' by gathering to oneself ever more instances of sameness, resemblance and self-replication....The term has a strong pejorative force, and suggests that the subject is seeking, in a wilful and blameworthy fashion, to remove himself from the flux of becoming" (92). Therefore, when Lacan associates the Imaginary order with the mother, he is placing them both in a lower hierarchical position than the father and the Symbolic order. The Symbolic order is "often spoken of admiringly. It is the realm of movement rather than fixity, and of heterogeneity rather than similarity. It is the realm of language, the unconscious and an otherness that remains other" (92). The Real "is the world external to the human mind, and the 'reality principle' lies in the individual's recognition that this world places limitations upon him as he pursues his pleasures" (94).

24. In "Lacan and Heidegger: The Ethics of Desire and the Ethics of Authenticity," in **From Phenomenology to Thought, Errancy, and Desire: Essays in Honor of William J. Richardson, S.J.** ed. Babette E. Babich (Dordrecht: Kluwer Academic Publishers, 1995), Richard Capobianco says that "For Lacan, the 'ethics' of psychoanalysis is an 'ethics' of human desire" (391). This is based on Lacan's theory that when the child breaks the
union with the mother which represented the imaginary order, a desire develops to return to that union. According to Capobianco, Lacan says that we must pursue our desire no matter what society says is important to pursue (393).

25. In "This God Which Is Not One: Irigaray and Barth on the Divine," in Transfigurations: Theology and the French Feminists eds. C.W. Maggie Kim, Susan M. St. Ville, and Susan M. Simonaitis (Minneapolis: Fortress Press, 1993), 109-141, Serene Jones explains that in western philosophy it has been necessary for the subject to have an interaction with the other in order to establish its identity. If the other does not reflect the same image, then "the contours of its shape would be endlessly fluid" (1993, 114). According to Irigaray, a fluid's qualities could be interpreted as being dangerous since it is uncontrollable. Therefore, the subject desires a reflection that is recognizable as itself which means it is limited by sameness.

26. As I will discuss in the final chapter relationships would be different if based on sexual difference because this new discourse would allow more freedom of interpretation and encourage more interaction rather than mere reflection based on sameness. With a discourse that promoted relationships which celebrated and appreciated the differences between persons, there would be possibilities for growth in society. A discourse of difference would allow us to address ethical concerns of health care relationships.

27. Margaret Whitford, in Luce Irigaray: Philosophy in the Feminine (London: Routledge, 1991), interprets Irigaray's description of the imaginary as "the unconscious of western thought - the unsymbolized, repressed underside of western philosophy" or "as something which does not yet exist, which still has to be created" (89). This interpretation fits with Irigaray's emphasis on sexual difference since it includes aspects of fecundity, or the becoming of a new discourse. Whitford further states that Irigaray's "symbolic is structure (form) which is given content by the imaginary" (91). As such, the imaginary precedes discourse.

28. In Textures of Light: Vision and Touch in Irigaray, Levinas and Merleau-Ponty (London: Routledge, 1998), Cathryn Vasseleu says that "Each time Merleau-Ponty refers to the reversibility of the visible, he includes touch with vision, reinforcing reversibility as a combination of touch-vision" (56).

29. In Textures of Light, Cathryn Vasseleu says "that if Irigaray is asserting that touch is the unique preserve of female eroticism then her comment would be as prescriptive as the economy she wishes to subvert" (17). She cautions that Irigaray must be read in the context that woman has not had the privilege of choosing between vision and touch, because she has been "dominated by the scopic"(17).

30. In "Irigaray's Body Symbolic," Hypatia 6 (Fall 1991): 97-110, Margaret Whitford summarizes some of the various interpretations that different feminists have given about Irigaray's use of lips. She says that the lips have been interpreted from a literalist and biological approach, as a "metaphorical subversion" of Lacan, as a symbol of the
imaginary, and as a deconstructive concept to defy binary oppositions (99-101). Whitford concludes that Irigaray is "not in control of this image any longer" and "the proliferation of readings" is what makes her image of the lips "impregnated with layers of symbolic meaning" (101). Since Irigaray's writing is an example of a feminine discourse, this multiplicity of possible meanings would be one of the inherent qualities of it. Therefore, I agree with Whitford's acceptance of the possibility of each of these interpretations having its merit.

31. In "Ethics revisited: Woman and/in philosophy," in Feminist Challenges: Social and Political Theory eds. Carole Pateman and Elizabeth Gross (Boston: Northeastern University Press, 1986), Rose Braidotti quotes Adrienne Rich as saying in 1976 that "I am convinced that there are ways of thinking that we don't yet know about" (57). Irigaray's work promotes being open to new ways of thinking and imagining woman's experiences and how they can be expressed. Margaret Whitford acknowledges Irigaray's recognition of woman's capacity for going beyond established boundaries, promoting multiplicity, and being able to "imagine the unimaginable" in Luce Irigaray: Philosophy in the Feminine (London: Routledge, 1991), 22.

32. In Revaluing French Feminism: Critical Essays on Difference, Agency, and Culture eds. Nancy Fraser and Sandra Lee Bartky (Bloomington: Indiana University Press, 1992), Nancy Fraser does not view the world as "wholly phallocentric" but much more as a composite of various philosophical strands and points of view that come in contact with each other and involve some tension (17-18). My reading of Irigaray is that she is interested in these other "points of view" having the capability of being expressed and heard. She is concerned that because the traditional discourse in society is so influenced by phallocentrism that these other voices cannot emerge.

33. Margaret Whitford, in Luce Irigaray: Philosophy in the Feminine (London: Routledge, 1991), explains that Irigaray is looking for opportunities which create "a place from which woman can speak as women" (124). Further, she says that since Irigaray uses language that is fluid, mobile, open, and unstable like her descriptions of woman, that she avoids using metaphors which have been used as the tool of western philosophy in an attempt to define and enclose woman within its parameters (37).

In Philosophical Perspectives on Metaphor (Minneapolis: University of Minnesota Press, 1981), Mark Johnson, ed., summarizes Aristotle's definition of metaphor as having the three following components: "(i) focus on single words that are (ii) deviations from literal language, to produce a change of meaning that is (iii) based on similarities between things" (6). Based on this definition, Irigaray would not encourage the use of metaphors that tried to make women "similar" to something that was established in the masculine discourse.

34. Nietzsche's understanding of metaphor was completely different from Aristotle's because he interpreted the world as having little fixed or literal meaning upon which to base truth. In "Nietzsche, Metaphor, and Truth," in Philosophy and Phenomenological
Research 43 (December 1982): 179-199, Lawrence M. Hinman interprets Nietzsche as saying that "language is not primarily literal; rather, it is fundamentally metaphorical" (180).

35. According to Margaret Whitford in Luce Irigaray: Philosophy in the Feminine (London: Routledge, 1991), in order for a new imaginary to be recognized and understood, "the monosexual cultural imaginary would have to open up to another sex, to make a space for the female sex; it would have to recognize the Other" (74). Irigaray explains that recognizing sexual difference is the first step in expressing a feminine imaginary.

36. Serene Jones, in "This God Which Is Not One: Irigaray and Barth on the Divine," explains that "the exchange between the sexes...is the fertility necessary for the production of a new world as much as for a new life" (1992, 211). She relates the development of a new discourse to Irigaray's description of sexual difference and procreation. This relationship of feminine discourse with fecundity is another way of indicating the potential for growth within sexual difference.

37. This is the technique that I will use to demonstrate how woman's voice has been overlooked by the traditional health care ethical methodologies. I will return to how Irigaray's work can be applied to health care relationships in the next chapter. Her work will be used to discuss how principism and casuistry have not included interpretations that affect women's traditional roles in health care.

38. In "Beauvoir, Irigaray, and the Mystical," Hypatia 9 (Fall 1994): 158-185, Amy M. Hollywood describes Irigaray's work on mysticism as a response to both Beauvoir and Lacan. Irigaray particularly argues against Beauvoir's insistence that only the masculine subject can be transcendent, and the only way that woman can attain transcendence is by becoming more like man. Irigaray argues for both "human embodiment and the possibilities of transcendence" for both genders (159).

39. This is important for Irigaray's work to be relevant to health care, since there are male nurses and physical therapists and female physicians. In the next chapter I will discuss the importance of both genders being open to both masculine and feminine discourse.

40. In The Mystic Fable: Volume One The Sixteenth and Seventeenth Centuries translated by Michael B. Smith (Chicago: The University of Chicago Press, 1992), Michel de Certeau describes how the "one has changed its site. It is no longer God but the other, and in a masculine literature, woman" (4). De Certeau explains how the divine word is replaced by the body, or the transformation of "faith into eroticism," in which "a body 'touched' by desire and engraved, wounded, written by the other, replaced the revelatory, didactic word" (4-5).
41. In "Beauvoir, Irigaray, and the Mystical," Amy M. Hollywood criticizes Irigaray's portrayal of mystics due to her "lack of attention to historical, contextual, and textual particularities" (160). She says that Irigaray emphasizes texts that promote the embodiment of the mystics without acknowledging the diversity among the mystics and saints. Irigaray's work on the mystics is even more obscure than her other mimicry of Freud and Lacan since she does not specifically quote text from the mystics as she does with the other writers she engages. Since I am using Irigaray's work on the mystics as an example of a feminine discourse, her obscurity enhances her depiction of a feminine discourse as something that may be unrecognizable.

42. Michel de Certeau discusses the difference in schism and heresy and defines heresy as existing "when a majority position has the power of naming in its own discourse a dissenting formation and of excluding it as marginal" (1992, 18-19). Although Irigaray does not use this term, she describes feminine discourse in a similar way as being marginalized by the dominant discourse of society.

43. In "Divinity and Sexuality: Luce Irigaray and Christology," Modern Theology 12 (April 1996): 221-237, Graham Ward gives Schleiermacher, Barth, Tillich, Rahner, and Moltmann as examples of this type of "second Adam Christology" (230).

44. In "This God Which Is Not One: Irigaray and Barth on the Divine," in Transfigurations: Theology and the French Feminists eds. C. W. Maggie Kim, Susan M. St.Ville, and Susan M. Simonaitis (Minneapolis: Fortress Press, 1993), pp. 109-141, Serene Jones interprets Irigaray as saying that "the God that will save women will be a God of their own creation, their own projection of all that is divine within them...between God and woman, there is no hierarchy because there is no difference" (137). Jones does not recognize God as creator since she claims that we create God. This interpretation of God appears to go beyond Irigaray's work. However, Irigaray's work says that the divine can be found in all places and that God is not fixed, static, or finite but is always in a state of becoming.

45. Margaret Whitford in Luce Irigaray: Philosophy in the Feminine (London: Routledge, 1991), agrees that Irigaray finds that the "divine is in language and ethics, i.e. it is firmly within the symbolic order, in its possibilities for becoming" (147). She argues that Irigaray does not present the divine as a new entity. She says that the "sensible transcendental is not a precise concept; it is a condensed way of referring to all the conditions of women's collective access to subjectivity" (47). Irigaray is trying to make us look at the world and the divine in a new way that will allow different interpretations and to have fuller meanings.
Chapter 5

Using Luce Irigaray’s Interpretation of Sexual Difference
to Address Ethical Issues Associated with
Interprofessional Relationships

Introduction

The goal of this chapter is to explain how Luce Irigaray’s description of a feminine discourse based on sexual difference can be used to supplement traditional ethical frameworks in addressing the ethical issues associated with interprofessional relationships. Although principilsm, casuistry, and care have been used to address many ethical issues in health care, I will explain how sexual difference, and specifically the recognition of the importance of feminine discourse can provide an additional dimension to the ethical analysis involving relationships.

Using Luce Irigaray’s work on sexual difference I will explain how a feminine discourse, derived from a feminine imaginary, grounded in sexual difference, and incorporating the qualities of multiplicity, fluidity, and intermediacy, could be used together with the traditional ethical analyses to address more effectively the ethical problems derived from interprofessional relationships. I will discuss how the obscure writing of Luce Irigaray could relate to health care’s discourse so firmly entrenched in masculine discourse. Although Irigaray does not address health care discourse directly, I will use her work as a basis to show how the use of feminine discourse could make ethical deliberations in health care, which directly affect patient care, more

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dynamic and relevant to all parties involved in the ethical issue. Her work will be used to focus on the following aspects of health care: the dissonance between masculine discourse and feminine experience, the relationship of gender and authority, the significance of appealing to the situational context and experience of the patient and provider, the encouragement of listening to multiple voices, and the importance of interdependence in making ethical decisions. In offering these propositions it will be necessary to recognize new possibilities for hearing and using a different discourse.

I will first present a case study that involves several health care providers with conflicting views regarding a decision about the care of a patient. This case can be addressed by using traditional ethical theories grounded in masculine discourse. If the traditional ethical analysis using principlism is employed in this case study, the case would appear to be a conflict between the principles of beneficence and autonomy, focusing on the physician and the patient. However, by using Luce Irigaray's work on gendered discourse, another level of analysis can be added that includes the recognition of the role of gendered discourse in these conflicts. One of the benefits of the recognition and inclusion of feminine discourse in ethical analysis would be the involvement of multiple voices in ethical deliberations. I will explain how the recognition of gendered discourse allows a deeper level of analysis in ethical issues derived from interprofessional relationships. I will further discuss why this type of analysis using feminine discourse may not be readily apparent to those not sensitized to feminine discourse.
I will explain how principlism, casuistry, and an ethic of care as described by Noddings\(^1\) traditionally have been dominated by masculine discourse, and therefore have been incapable of adequately addressing the ethical concerns that arise from health care relationships. Because these methodologies are grounded in masculine discourse, they have been inadequate in addressing ethical concerns involving situations that do not conform to the static characteristics of masculine discourse. Since relationships involve dynamic and evolving issues, a discourse sensitive to these characteristics is needed. One of the most important concerns of my work involves how patient care is affected by the limitations of the traditional ethical methodologies. I will describe the consequences of the sole use of masculine discourse in health care ethics. These consequences involve the possibility of harm not only to the patient, but also to the providers of health care. Harm could occur to the patient due to the lack of cooperation among health care providers. Nonphysician providers can be affected by a lack of respect for their obligations to patients, by a collapse of self and other, and by an inability to recognize the ethical issues related to interprofessional relationships when only masculine discourse is used in health care ethical analysis.

I am not advocating that these three ethical frameworks be forsaken, because they have served to help mediate certain ethical dilemmas in health care. Rather, I am proposing that there are other possibilities for ethical deliberation, grounded in sexual difference, that would address ethical considerations specifically involving health care relationships. By recognizing the extent to which discourse has been influenced by the masculine
perspective and the dangers associated with the belief that language is neutral, we can become more sensitive to those gendered societal practices that have arisen within this limited symbolic system. Since health care ethics has been so firmly based in masculine discourse, I will conclude by discussing the ramifications that the recognition of feminine discourse has for traditional ethical analysis in health care.

**Case Study**

The following case scenario will illustrate how ethical concerns in health care are related to interprofessional relationships. Throughout this chapter I will discuss how traditional health care ethics might analyze this case using masculine discourse, and then how it could be looked at differently if a feminine discourse were used. I will discuss how the consequences of this case using the two discourses would be different, and how they would affect both the patient and the health care providers.

Retrospective End-of-Life Case Study:

Mr. Green was a sixty-eight-year-old male who was diagnosed with lung cancer two years ago and previously had been treated at this 250-bed hospital with surgery, chemotherapy, and radiation. He was admitted for the fourth time to this nursing unit because the cancer had metastasized to his brain. Mr. Green had been a teacher of journalism at the community college for a number of years and has a very supportive wife and two adult children.
Although Mr. Green had not signed an advance directive, his family told the nursing staff that Mr. Green had told them that he did not want any life-sustaining interventions performed at the end of his life, especially when he was no longer conscious of his environment. The family said that they supported Mr. Green’s decision. He had also told several of the nurses during previous admissions that if the time came when he could no longer interact with his family, then life would not hold any meaning for him. When he entered the hospital, Ms. Stone, who had been his primary nurse during the previous admissions, was once again assigned to his care. She asked him if his feelings were the same about limiting the care at the end of his life. He indicated that indeed they were the same. She asked him why he did not have an advance directive, and he said that he did not think it was necessary. Since Ms. Stone believed that she had developed an emotional bond with Mr. Green during his multiple hospital admissions, she spoke with him about his feelings regarding his diagnosis and his care.

On a previous admission he told the physical therapist, who was working with him in an effort to improve his endurance and ability to perform functional activities, that he would never want to live "like a vegetable, tied to tubes and needles." The nurses and physical therapists had informally discussed his comments and agreed that he presented a good case for the limitation of care. None of these health care providers documented Mr. Green’s comments in the medical record³.

Mr. Green had a relationship with a family practice physician for 20 years, yet when he
became eligible for Medicare, this physician was not on his HMO list, so he could not afford to continue to see this physician. Since joining the HMO Mr. Green had been assigned to several different physicians who had directed his care, and he had been seeing Dr. Peel, his current primary care physician, for six months. In addition, there were several other physicians involved in his care, including an oncologist, a pulmonologist, and a neurosurgeon.

Mr. Green developed problems breathing and caring for himself. He needed maximum assistance for all of his daily needs, including eating and bathing. He could not walk and could only communicate with nods of his head or his eyes. Although Mr. Green had lung surgery two years ago, a neurosurgeon had determined that surgery was not indicated for his brain tumor. Mr. Green had already completed treatments using radiation therapy and chemotherapy for his brain tumor without significant improvement in the tumors. His tumors were no longer being directly treated.

Since Mr. Green could no longer take food orally without choking, a nasal feeding tube was inserted with the possibility raised of inserting an abdominal tube. Within the last two days, dialysis had been started due to his deteriorating renal function. Since his pulmonary function was decreasing, Dr. Peel notified the family that he would soon need a ventilator to assist his breathing. Dr. Peel told the family that if Mr. Green were placed on a ventilator, he would be moved to the ICU for care. Each of these steps (the nasogastric tube and dialysis) had been taken in succession after Dr. Peel discussed their
necessity with the family. Each time the family told the physician that they could not make these kinds of decisions and told the physician to do what "he thought was appropriate." They said that they could not make a decision that would end his life.

Dr. Peel decided that it was time to place the patient on a ventilator and to admit him to ICU, and he wrote the order in the medical record. Nurse Stone had been in attendance each time when Dr. Peel had spoken to the family and had witnessed the family crying and obviously distraught over the impending death of Mr. Green. Ms. Stone had been so concerned that the patient was about to be treated in a way that he had not desired, she had spoken with other nurses about this case. The other staff members agreed with her, but they would not agree to speak to the physician since they said that "Dr. Peel had the legal responsibility to make the decisions for the patient." She decided to speak with Dr. Peel about the patient's wishes to not have life-sustaining treatments.

Ms. Stone told Dr. Peel that Mr. Green had spoken to several members of the staff about his desires to limit life-sustaining treatments. Nurse Stone said that she felt it was her obligation to the patient to try to uphold his wishes. She said that she felt that the family was in such an emotional state at this time, that they could not make the necessary decisions for Mr. Green even though they had previously agreed with him. She said that she had doubts about starting the artificial hydration, nutrition, and dialysis, but that she believed that Mr. Green had been clear about not wanting to be separated from his family. She told Dr. Peel that she believed that placing the patient on the ventilator
would be causing the patient undo harm since the treatment is so uncomfortable and the patient would have to be in ICU separated from his family. Ms. Stone told Dr. Peel that over the years of caring for Mr. Green she had grown close to both him and his family, and she felt that the patient believed that his wishes would be fulfilled. Further, she said that the patient’s rights of autonomy were being violated. Ms. Stone told Dr. Peel that there might be other options to consider, such as specifying a time limitation for the ICU stay or a referral for hospice care.

Dr. Peel told Ms. Stone that this matter was none of her business. He told her that her only obligation involved "doing what she was ordered to do without comment." The physician also told the nurse that since the patient did not have an advance directive, his primary medical obligation to the patient was to provide the best medical care possible. In this case he said that the standard of care dictated that he assist the patient with his breathing and that a ventilator was necessary. Dr. Peel said that only his obligation to the patient was what mattered and that she was over-stepping her bounds. The nurse was told not to speak to the patient’s family, and when she objected, she was reassigned to a different nursing unit after the physician reported her "insubordination" to the nursing administrator.

Ms. Stone believed that Mr. Green had made his wishes clear and that he was being treated poorly. She contacted the chair of the ethics committee of the hospital and explained the situation to Dr. Jones who was the chair of the committee. He told her
that this case was not an ethical dilemma since the patient did not have an advance
directive and the family had concurred with all of Dr. Peel’s recommendations. Dr.
Jones told her that the committee can not become involved in "personnel issues." Ms.
Stone was not surprised by her discussion with Dr. Jones since he was a partner of Dr.
Peel. She already was aware of several occasions when nurses had tried to have cases
brought before the committee but were told that the cases "were not ethical issues" by
this physician. The patient was transferred to the ICU, intubated, and placed on the
ventilator. He died two weeks later.

Ethical questions raised by this case include: Were the patient’s desires honored? What
are the nurse’s obligations and who should make the final decisions in this case? Why
did the physician not incorporate the information about the patient’s wishes into his
decision-making? Why does the ethics committee not provide recommendations in this
case? Other ethical issues that will be addressed include the possibility of harm to the
patient, the nonphysician health care provider, and the physician.

Significance of Irigaray’s Work

for Health Care Ethics

Before directly addressing the case study, I will discuss how Irigaray’s work has
significance for health care ethics in general. Her work describing the feminine
imaginary will be used to help uncover aspects of ethical issues that have gone unnoticed
by the dominant masculine discourse. The above case will be used to illustrate how the phenomenon of overlooking feminine discourse has occurred and its consequences on patients and providers. Examples of how the feminine imaginary opens up new possibilities for examining health care dilemmas will be presented. Irigaray’s critique of the historical prioritization of sight over touch is also relevant for recognizing how health care ethics has been dominated by masculine discourse. A specific ethical dilemma illustrating how this hierarchicalization of sight over touch has affected patient care will be discussed. Finally, I will return to Irigaray’s phenomenological interpretation of human bodies, especially the female body, and how her hermeneutics can be applied to health care ethics. Using her descriptors of multiplicity, fluidity, and intermediacy, I will explain their applicability to the case study and how gendered discourse would enhance the traditional analysis of this case.

The Role of Feminine Imaginary and Gendered Discourse in Health Care

Since the health care environment traditionally has been thoroughly inundated in masculine discourse, health care providers may find it difficult to recognize the feminine imaginary. Further, the educational and institutional environments of health care providers utilize the dominant masculine discourse, and therefore providers are socialized to use the language of those in authority⁴. Those who use another form of discourse risk either not being understood or being dismissed (figuratively and literally)⁵. One may recognize the feminine imaginary in a subtle manner as in an uncomfortableness with the
status quo. A person may sense that what one feels and what one experiences are not compatible. This sensation of dissonance can be a signal that perhaps there is something more than what we have traditionally recognized as the norm. Although Lacan claims that there is no pre-discursive reality, the experience of this dissonance and the subtle signals recognized by those sensitive to an imaginary that is different from what is described by masculine discourse provides an argument that a feminine imaginary exists. There are obstacles to accessing a feminine imaginary as it emerges from the unconscious into a symbolic system. As Irigaray explains, we must allow those fragments of a different discourse that come to us as residue or supplement, to emerge from within our unconscious, so that we may find something that sounds more familiar than the traditional discourse of indifference. As this transition occurs, masculine discourse has historically mediated and controlled the resulting symbolics. If a feminine imaginary is to be discovered, it must emerge from the unconscious without the intrusion of the masculine symbolic system.

Sexual difference can provide a means by which we can recognize a different imaginary. Irigaray’s interpretation of sexual difference extends beyond the biological body to how the different sexualities can represent different meanings. Irigaray describes how woman can become other than a male reflection by paying attention to her body’s interpreted qualities. Irigaray interprets the multiplicity of female sexuality, the fluidity of her body, and its creative role as an intermediary, as examples of how woman can be interpreted differently from the singular, solid, and static qualities of male sexuality. By recognizing
that these differences affect our interactions with the world, we can become aware of a
different imaginary. By sensing that there is more than the one truth that is dictated by
masculine discourse, a feminine imaginary can emerge. Irigaray claims that a feminine
imaginary would be attuned to infinite and ever-changing possibilities. If we can
recognize a feminine imaginary, the next step is to find a way to express it in a discourse
that can be utilized in addressing the ethical issues that have been identified as associated
with health care relationships.

Gendered discourse involves using an interpretation of the body as it experiences the
world. Irigaray has found notable phenomenological differences in the relationship of
female and male bodies with the world around them by interpreting their differences in
sexuality. This is in response to those earlier philosophers and analysts who determined
that all persons developed the same and who used the sexuality of the male as the norm.
She is not claiming that all women and all men have similar experiences since claiming
that would be opposed to her pursuit of difference. However, Irigaray has recognized
that women's bodies can be similarly interpreted due to the multiplicity of their sexual
organs that provide them pleasure. While men may also derive pleasure from multiple
sites, the emphasis in western philosophy and psychoanalysis has been on the importance
of the penis and how it has been interpreted as singularly providing male sexual pleasure.
When interpreted to mean more than the biological penis, the term phallus is used to
entail a philosophy in which there is a focus on finding the one truth, on hierarchies
based on the dominance of sameness, and the importance of the identification of
boundaries so that systems are based on stability.

In response to the dominance of phallocentrism, Irigaray interprets other characteristics of the female body that have been overlooked by a discourse that can not recognize them. As discussed in the previous chapter, her interpretations of the meaning of the lips, of fluid, and woman's maternal functions has also been different than previous interpretations and descriptions. Irigaray, by recognizing a feminine imaginary, is able to access a discourse that seems odd and unfamiliar to ears attuned to masculine discourse. She associates this discourse with characteristics of the female body that are different than those most often noted by masculine discourse. She interprets woman’s experience through her body as having multiple sites of pleasure. She celebrates the fluids of the female body and interprets them as allowing woman to have an openness and mobility that is uncontained and uncontrollable, and leads her to associate woman with the properties of fluids. Further, woman’s role in procreation is interpreted by Irigaray as one that places woman in an intermediate role with transformative and creative properties.

It is imperative that gendered discourse be used commensurate with its basis in interpretation and not in biology. Since all physicians and all nonphysician health care providers cannot be associated with a specific gender, gendered discourse cannot be used rigidly and applied to specific groups of persons. Even in the gender-segregated environment of health care, it is important not to attempt to designate a gendered
discourse with specific groups since there are female physicians and there are male nurses and physical therapists. It would be untrue to state that physicians always use masculine discourse or that nurses and physical therapists always use feminine discourse. However, as I have discussed in previous chapters, the institution of health care is grounded in masculine discourse. Further, the discourse of health care is overwhelmingly from a masculine perspective, especially since the masculine-dominated medical profession has been in the position of authority. Those who find masculine discourse not reflective of their experience may be those in the positions of lower authority whose roles can be interpreted to have feminine characteristics. It is important to reveal by interpretation the gendered aspects of health care roles, both feminine and masculine, so that these components can be used positively in the ethical analysis of health care relationships. Because the language of health care ethics is also influenced by masculine discourse, it has been limited and has been insufficient in the analysis of interprofessional relationships. Because these relationships have dynamic elements of feminine discourse, the traditional health care ethical frameworks, grounded in masculine discourse, have proved inadequate in their analysis.

**Feminine Imaginary and Gendered Discourse in the Case**

The first step in recognizing the possibilities for the use of sexual difference in health care is to be open to the voice of the imaginary of both genders. Since the imaginary is in the pre-discursive realm of the unconscious, it may be revealed to us in various and subtle ways. Irigaray has explained the importance for listening to what sounds unusual
or different as that which may be the feminine imaginary unmediated by the more recognizable and traditional masculine discourse.

To explain how the feminine imaginary can play a role in health care ethics, I will return to the case study. If this case is analyzed using the traditional masculine discourse of health care ethics, specifically principlism, it would involve at least two conflicting principles. The traditional ethical concerns would involve the conflict between the physician’s determination that beneficence dictated continued treatment for the patient versus not respecting the patient’s autonomy to decide to limit treatment at the end of his life. However, since the patient can no longer express his wishes and the family has deferred to the physician’s decision, there would be no question of an ethical dilemma in this case without the nurse acting on behalf of the patient. If the focus of this analysis were between the patient’s right of autonomy and the physician’s obligation of beneficence, an ethical discussion may not ensue because the physician does not recognize that there is an ethical issue and the patient is incapable of expressing his wishes at this point. In reality, this type of case occurs frequently without discussion of possible ethical ramifications.

Since the physician traditionally has the sole decision-making authority, without the voice of a third party willing to be an advocate for the patient when the patient can no longer speak or make decisions, there would be no questions raised regarding the ethics of the physician’s decision. This case analysis will focus on why the nurse was prevented from
expressing her concerns regarding the physician’s decision to pursue life-sustaining treatments for this patient.

If any of the nurses or the physical therapist had written Mr. Green’s comments regarding his wishes to limit end-of-life care in the medical record, the physician’s decision could have legitimately been challenged and the ethical question would have been framed from a traditional beneficence versus autonomy perspective. Since the case does not explain the nonphysician caregivers’ motives for not writing this information, I will propose possible reasons based on gendered discourse. Although nurses and physical therapists must legally document patients’ responses to treatment in the medical record, in this case Mr. Green’s expressed preferences were not written in the chart. Many nonphysician caregivers learn that their notes in the chart are not read by physicians and document only information that would be considered "objective" regarding their care-of the patient. This could be associated with a masculine discourse in which only information that can be quantified or visualized would be considered pertinent for the medical record. Since the patient’s wishes were discussed with these caregivers at times when there was an emotional component involved in the interaction, the nurses and physical therapists may not have considered this information appropriate to be recorded in the chart. As I discuss the role of gendered discourse in this case, I will refer to this missing documentation, which can be associated with a feminine discourse.

Why would this nurse risk challenging the physician’s decision regarding the care of this
patient? I will argue that she was able to sense something beyond the conflicting
principles of beneficence and autonomy (although, as I will explain, she also considered
the relevance of these principles). Perhaps she was able to recognize that there was
something missing in the decision-making process that would allow her patient to receive
treatments that he had refused on several occasions. She recognized that there were
voices missing in this decision, and that it was made without all of the relevant
information necessary to make a decision. As a nurse, her role allowed her to fill a
unique position in health care as a mediator between the patient and physician. In the
case Dr. Peel did not allow her to fulfill this role. Ms. Stone became aware through her
feminine imaginary that there was a greater depth to her role in patient care.

Using Irigaray’s interpretations of the female body as multiple, fluid, and intermediate,
I will explain how this nurse was able to access her feminine imaginary by recognizing
the unique value of those qualities. As a nurse who was in an overwhelmingly female
profession in a masculine dominated environment, multiplicity played a dominant role
in her work. While Irigaray discusses the pleasure that woman experiences in her
multiple sites of sexuality, nurses also seem to excel in filling multiple roles in health
care. They must be able to flourish in an environment where they are institutionally
lower in the hierarchy than physicians, but where they are often the first line of
communication with patients. They not only carry out the orders of the physicians, but
they also respond to patients’ needs and serve as advocates for the patients. By
remaining silent, Ms. Stone could have remained within the masculine discourse of health
care that traditionally recognizes the physician as the sole decision-maker for the patient. However, this nurse could not ignore her feminine imaginary sending her signals that caused her to experience an internal discomfort.

Since Ms. Stone was working within the institution of health care, she was accustomed to functioning within the familiar masculine discourse. She did not initially confront Dr. Peel when Mr. Green was first given artificial nutrition and hydration or when dialysis was begun. Perhaps she unconsciously was trying to balance the uncomfortableness she felt on behalf of the patient with her role in the hierarchy of the institution. Her imaginary made her sensitive to the multiplicity of her roles in patient care, which included advocating for the patient as opposed to the traditional expectations of health care that she relinquish all decision-making authority to the physician. When she spoke on behalf of Mr. Green, Ms. Stone was responding to the dissonance between the care that her patient received and what she believed he had wanted. Because her unconscious awakened her sense of multiplicity, the nurse risked becoming involved in the decision-making process on behalf of her patient.

Irigaray also interprets woman's body as having the quality of fluid. Not only does she describe woman's biological fluids as unique but also how those fluids can be associated with woman's dynamic status in the world. The work of hospital nurses in general is of a fluid nature in that they must be able to move from patient to patient and interact with multiple other health care providers. They receive and give information to many people.
They are constantly interrupted in their duties, but must be able to flow from one task to another. In the case Ms. Stone had a fluid relationship with Mr. Green. She was able to listen to the patient on multiple hospitalizations and interact with the family. She had heard the family’s concurrence with the patient regarding his preference for a limitation of treatment at the end of his life. This nurse recognized the family’s reluctance to make the difficult decisions about their loved one, but she knew that they had expressed deep feelings about his care. She understood that the decisions regarding which treatments to limit were difficult to make, especially deciding when to stop providing life-sustaining care. These types of decisions have a fluid nature about them, as one treatment seems to flow naturally into another one. Ms. Stone recognized that although the patient had voiced his preference not to have life-sustaining treatment, it was difficult to know exactly which specific treatments should be withheld. The decisions to provide or to withhold nutrition, hydration, antibiotics, dialysis, assisted breathing, or resuscitation require the recognition of how a patient's condition may fluctuate and are made in a dynamic environment in which uncertainty is a factor. In such an environment, the nurse recognized that the fluid nature of her relationship with the patient had placed her in a position to learn his preferences regarding end-of-life care. When she recognized that Mr. Green was about to receive a treatment without consideration of his wishes, she was compelled to voice her concerns about the patient’s treatment.

Without the nurse’s objections to the placement of the patient on a ventilator, there would not have been a discussion of an ethical issue because the physician had already been
given the decision-making authority. The nurse chose to listen to the signals emanating from her feminine imaginary that caused her to recognize that there were voices involved in this decision other than those represented by a masculine discourse giving the sole authority of decision-making to the physician. Irigaray describes a third quality of woman as being intermediate that can be interpreted from her maternal role. According to Irigaray, the maternal role of woman can be interpreted as providing a means for interaction, creativity, and change to occur. The quality of intermediacy can be associated with nurses as they are often in the central position in the hospital environment as caregiver to patients. Nurses are accustomed to serving in this intermediate role since they often serve as the mediators between health care providers, families, and patients. As they provide patient information to physicians and interpret medical terminology for patients, nurses fulfill an important position of dissemination and translation of information. As I have described in previous chapters, nurses reside within several hierarchies in health care, with physicians, administrators, and other health care providers. In order to be able to function within this complicated environment, nurses must not only recognize where the established lines of authority exist, but they must also be cognizant of their primary obligations to the patient. Therefore, in this case the nurse risked opposing the physician who had the legal and institutional authority to make end-of-life decisions for patients, to express concerns that she had derived by paying attention to an unconscious source, a source that placed her concerns outside of the accepted masculine discourse. As she allowed her qualities of intermediacy to rise to the surface from her imaginary, the nurse was able to become an advocate for the patient.
This nurse could have remained safely within the traditional masculine discourse, but she began to realize that what was happening to the patient was not in congruence with what the patient had expressed. Instead of allowing the masculine discourse of the health care environment to overwhelm her and thus dismiss these signals, the nurse attempted to translate what she derived from her feminine imaginary into a discourse that was different from others. Later I will return to how the qualities of multiplicity, fluidity, and intermediacy associated with feminine discourse could further be used in the ethical analysis of this case.

Touch and Sight

I will digress briefly to discuss one particular aspect of Irigaray’s work that has specific application to health care. This is an example of how the phenomenological work of Irigaray can be applied directly to health care ethics. I will return to the more general topic of feminine imaginary and discourse following this section. While she does not discuss touch and sight in the context of health care, it is one more illustration of how Irigaray’s hermeneutics has relevance for health care ethics. Irigaray’s criticisms of the work of Merleau-Ponty and Lacan in which they prioritize sight or touch has ethical significance for health care relationships. As I discussed in the previous chapter, Irigaray associates sight with indifference as it closes the senses within a reciprocity of sameness. For Irigaray, touch promotes an openness that is sensitive to difference while she interprets sight as closure. This dichotomy between sight and touch is particularly pertinent in health care and helps further illustrate how the masculine discourse has
maintained its position of superiority. Previously I distinguished nonphysician health care providers as those persons who provide more "hands-on" care of patients from physicians whose traditional responsibilities have involved establishing a diagnosis and making decisions. These distinctions can be seen more in the hospital setting, where touching occurs more frequently by nurses who provide the ongoing care of patients and physical therapists provide the rehabilitation of patients. Physicians touch patients to palpate, to perform surgery, or to perform other specific tasks, but in the hospital setting, physicians' duties often involve less touching than when they are practicing in their offices where nurses have less of a hands-on role. Further, in the hospital setting, physicians use their skills of observation and inspection when examining patients and reports of diagnostic tests, thus using vision as a means of gaining knowledge about the patient to help in the determination of a diagnosis and treatment plan. On the other hand, the tasks that nurses and physical therapists perform with patients almost always involve touching patients in the administration of treatment or in providing comfort. Skill in observation is also important for these nonphysician health care providers, but what sets them apart in the hospital setting is their patient handling skills.

Instead of trying to prioritize one sense over the other, as traditional masculine discourse has done with the help of Merleau-Ponty and Lacan, Irigaray does not attempt to promulgate a new hierarchy. Her work should sensitize us to how specific historical interpretations, such as placing vision in a superior position over touch, has ramifications for those in health care and how they relate to each other. Irigaray explains that sight
has traditionally been placed in a higher position hierarchically than touch by the traditional masculine discourse. Therefore, since physicians have been more generally associated with sight phenomenologically, they have maintained the hierarchically superior position among health care providers. According to Irigaray’s interpretation of sexual difference, neither touch nor vision should be placed in a hierarchical arrangement. Instead, they should both be valued for their specific uses in health care. Irigaray does not advocate inverting the hierarchies, but sexual difference can be used to show how each of these senses is valuable and should be recognized for their significance to both genders. I argue that this is applicable to providers of health care, and that patient care would be diminished if either touch or vision was eliminated from the process. In fact, patient care improves as these senses work together interdependently to provide the necessary feedback about a patient’s condition.

I have added the following case study to address the specific aspects of Irigaray’s discussion of sight and touch. It will illustrate how touch and sight can become factors in ethical dilemmas regarding patient care. I am using this case to show that ethical issues in health care that appear to be merely the consequences of conflicting principles may actually be based on phenomenological factors that can be revealed by the use of feminine discourse. This case will help delineate how touch and sight can work together to provide better patient care.

An eighty-one-year-old patient was brought to the emergency room from a nursing home
with a fractured hip after falling while being transferred out of bed into a chair. The patient was confused and in considerable pain. She was unable to give any medical history and her capacity to make decisions was questionable but was not directly assessed at the time of admission. The patient was a widow and had no children, and no other family were known. When the patient was admitted to the nursing home, she had given the administrators of the facility the power to make medical decisions for her in case of an emergency. Surgery to repair the fractured hip was approved.

The patient did well in surgery and when the orthopedic surgeon visited the patient the following day, she was awake, without complaints, and her bandage was clean and dry upon inspection. The physician wrote an order for the physical therapist to begin gait training immediately with this patient, which was standard procedure in this hospital. Everyone agreed that early ambulation was best for post-operative hip surgery patients to prevent the possibility of emboli.

The physical therapist explained the process of rehabilitation to the patient and then began to evaluate the patient’s available strength and functional ability. The patient was quite pleasant and appeared to have adequate upper extremity and trunk strength to begin the first steps of gait training that involved instruction in transfers to a chair. Although the patient had been responding to the therapist’s questions, the therapist was unsure about the accuracy of the answers regarding her pre-operative level of mobility since the patient provided only one-word answers or nodded her head. The therapist slowly
proceeded to assist the patient to move from a supine position to a sitting position, but the patient began to scream and tell the therapist to leave her alone. The patient also physically pushed the therapist away and tried to scratch the therapist. After several attempts to calm the patient and to proceed without success, the therapist alerted the nurses to the situation who also acknowledged that the patient screamed whenever they touched her. The therapist documented in the medical record that the patient adamantly refused the treatment.

The following day when the orthopedic surgeon made rounds the patient appeared to be in no physical distress and nodded in agreement with the physician when asked if she would like to get up and walk. The physician was distressed at the note that the physical therapist had written because the patient appeared capable of proceeding with the rehabilitation. The physician wrote in the medical record that "the patient should not be allowed to refuse physical therapy treatment." However, when the therapist attempted a second and third time that day to work with the patient, the patient behaved the same way by screaming and pushing, causing a great deal of commotion on the nursing unit. The therapist attempted to telephone the physician who would not speak to the therapist, but had the office nurse reiterate the orders that had been written in the chart.

This case can be analyzed as a conflict between the principle of beneficence as seen by the physician and the principle of respecting the patient’s autonomy as seen by the therapist. The physician’s position to treat the patient even against the patient’s wishes
would theoretically provide a medical benefit to the patient in preventing surgical complications. The therapist may believe that by not respecting the patient’s wishes, and forcing the patient to have the treatment, that the patient could be physically and emotionally harmed if she is handled by force. I will return to possible ways of solving this dilemma, but first the relevance of Irigaray’s discussion of sight and touch will be discussed.

In many cases of this type, the patient’s mental competency is never adequately assessed so we do not actually know whether she comprehends her right to make her own decisions or the decisions she is asked to make. Therefore, health care providers often respond to the patient’s current behavior without assessing the overall picture. In this case the physician performed the surgery on the patient, and thus participated in extensive touching of the patient and determined that the surgical repair was sound and that the patient’s physical condition should allow progression to ambulation. However, this touching occurred when the patient was fully anesthetized and unaware of the physician’s touch. The physician’s post-surgical care of the patient involved mostly visual observation of the patient who appeared to a pleasant, cooperative patient who agreed with the physician. When the physical therapist used her visual skills to assess the patient, the patient also appeared pleasant and compliant. When the therapist or the nurse began to touch the patient, the response changed.

The physician’s insistence on invoking the principle of beneficence that would involve
having the patient begin to be mobile was based on the sense of vision. The physician made the determination that the patient could begin rehabilitation by obtaining information visually. The therapist's decision that the patient had a right to refuse treatment was based on information gained through touching the patient. If this case were analyzed as only a conflict between beneficence and autonomy, using the standard dominant discourse of health care ethics, the outcome for the patient would be inadequate or even harmful. If the patient were allowed to remain in bed, her morbidity risk would be high. Yet if she were physically forced to get out of bed, her blood pressure could have risen, she could have resisted so much that she caused further damage to her hip, or she may have been harmed emotionally and never participate in rehabilitation so that she would not achieve her highest functional ability.

If sight and touch were both considered in her rehabilitation, compromises may be accomplished. This would also entails the recognition that instead of a masculine discourse in which vision is prioritized over touch, that a feminine discourse of fluidity, multiplicity, and intermediacy could be of benefit for the patient. If fluidity were allowed to be a part of addressing the patient's care, instead of insisting on the standard practice of early gait training, perhaps a less upsetting plan of care, such as beginning with bed exercises or sitting on the side of the bed could be initiated with a more gradual and fluid progression to possible ambulation. Instead of ambulation being the primary goal of the post-operative care, the patient's situation seemed to dictate that less aggressive goals be established with more multiple intervening steps. It might even mean
re-evaluating the possibility of ambulation as a realistic goal. Further, someone such as the therapist or nurse should act as the mediator in this case. The physician and the nonphysician caregivers need to be able to share information more directly, especially when it is obtained by the use of different senses. To promote a better interprofessional understanding, the physician could be shown the violent reactions of the patient when she is touched. Further, the physical therapist could be present when the physician is observing the patient’s compliant behavior to understand why the physician has been so insistent on the progression to ambulation. The patient’s behavior and statements would need to be carefully documented in the medical record so that what was obtained both through touch and sight would be recorded. This combination of sight and touch would lessen the resulting hierarchicalization of the principles of beneficence and autonomy, and thus allow for better care of the patient to ensue.

Balancing Gendered Discourse

An important aspect of Irigaray’s description of sexual difference is her recognition that both feminine and masculine discourses have beneficial characteristics. Instead of seeking a new hierarchy with woman in the superior position, she focuses on recognizing the benefits of multiple discourses and the necessity for a feminine imaginary to emerge into discourse. My goal is to apply her interpretation of sexual difference so that feminine and masculine discourse can become components of health care ethics. An acknowledgment of sexual difference would be the first step toward an ethic that would be open to more interpretations than the traditional one of the masculine discourse.
Further, I will discuss how utilizing aspects of both masculine and feminine discourse in the analysis of ethical issues that arise from health care relationships could lead to a greater understanding of why conflicts develop within these relationships. When ethical dilemmas arise, a greater recognition of different discourses and a phenomenological understanding of how they affect the relationship could provide a more thorough analysis of the situation.

Since a feminine discourse would reflect characteristics of woman's sexuality that include multiplicity, fluidity, and intermediacy, this discourse would encourage multiple voices and interpretations to enter the analysis of relationships. This is not a proposal for chaos. The positive qualities of masculine discourse must also be recognized which will help mediate these more dynamic qualities of feminine discourse so that when a health care dilemma occurs, a resolution can ultimately be achieved. Returning to the end-of-life case study, the question involved deciding whether to admit the patient to ICU on a ventilator or to allow him to die without further life-sustaining interventions. I will provide examples of how feminine and masculine discourse can be woven together with traditional health care ethical analyses to arrive at a decision. This is not a proposal to place one discourse in a hierarchical arrangement with the other, but one that, like Irigaray, is opposed to developing further separations in society. She says:

Rather than maintaining the masculine-feminine opposition, it would be appropriate to seek a possibility of nonhierarchical articulation of that difference
in language (TS 162).

The challenge is to try to find ways in which we can grasp the meaning of our bodies and convert those interpretations of fluidity, multiplicity, and intermediacy, into a discourse that can be recognized by the traditional, hierarchical, and static discourse of the health care system. The goal is to reveal how a gendered discourse can be used in health care to address the ethical concerns derived from interprofessional relationships.

In the case regarding end-of-life decisions, feminine and masculine discourse can be used together to suggest possibilities for addressing the dilemma that is presented. Using Irigaray’s phenomenological work on sexual difference as a basis, the following proposals seek to illustrate how balancing the use of both feminine and masculine discourses have positive consequences for patient care. I will use the qualities of multiplicity, fluidity, and intermediacy as qualities of a feminine discourse that can be balanced by a masculine discourse represented by limitations, boundaries, and structure.

A balancing of gendered discourse would involve the acknowledgement that different persons may invoke different imaginaries. If a feminine imaginary can emerge from the unconscious and become feminine discourse, health care ethics may be influenced by a different type of discourse than the traditional discourse that has been used with principlism, casuistry, and care. For example, when the obligations of the various health care providers are considered, the feminine discourse of nonphysician health care
providers, reflective of their qualities of multiplicity, would present interpretations of obligations other than those of physicians. This would allow a discussion of principles from a different point of view⁹. An analysis using gendered discourse would promote a greater understanding why the specific principles are chosen by health care providers to invoke. I do not advocate trying to eliminate or overlook the importance of specific characteristics of masculine discourse that would provide a balance to feminine discourse.

Masculine discourse may provide a balance to multiplicity by offering appropriate limitations to how many voices to include when a decision needs to be made. In this way a decision would not constantly be deferred due to the inclusion of too many voices for a decision to be determined. A balancing of gendered discourse in health care would involve both the inclusion of feminine discourse to allow a greater representation of voices in health care by those with patient obligations and a masculine discourse of limitations to provide procedural guidance for decision-making. For example, in the end-of-life case, guidelines may be established by the ethics committee so that any concern brought to the committee would be reviewed by at least three persons from various professions, instead of placing all of the authority for the determination of what cases are discussed in one figure. Further, the committee could determine how the voices of a variety of health care providers who care for the patients involved in ethical dilemmas could be sought to provide input into the ethical discussion. This would result in the nurse’s concerns being considered by more than the physician chair of the committee and could encourage other patient caregivers to come forward to participate in the discussion.
Feminine discourse also includes the characteristic of fluidity, which can be associated with a language and communication that is open and dynamic. In health care this would allow different ideas to be considered, not just the traditional ones that have been a part of the status quo. To avoid feminine discourse being so viscous that it cannot ever come to an agreement, masculine discourse, if carefully utilized, could offer necessary boundaries to help direct the decision-making. These boundaries would not be rigid and inflexible, but would offer some structure to the analysis. In the case fluidity would play a role by encouraging health care providers to openly communicate the reason that they claim a certain position. If the providers could recognize the phenomenological influences of the various roles of persons working with patients, they may be able to tolerate alternative possibilities for the outcome of this case. Masculine discourse would play a role by having established procedures about how these discussions would ensue to promote an efficient use of time and energy. In this case Ms. Stone and Dr. Peel are influenced by their positions based on their various interactions with the patient and family. Dr. Peel’s decision is influenced by his authoritative position in health care, and Ms. Stone is influenced by her position of assessing the patient’s psychosocial responses to treatment. By understanding the basis of their arguments, they may be able to achieve a compromise position that may involve a limited time in the ICU or hospice care.

Feminine discourse also includes the characteristic of intermediacy. Irigaray interpreted woman’s role in maternity as providing the means of creating life as a process, and as such, feminine discourse would reflect this quality as playing a role of mediation. A
feminine discourse of mediation in health care would promote more information to be exchanged between health care providers that would create an environment of connectedness around the patient. Masculine discourse would provide the balance of organization to carefully direct the newly formed lines of communication in a manner to best benefit the patient. In the case Ms. Stone is attempting to be an intermediary between the patient's desires and Dr. Peel's orders. However, Ms. Stone is not successful because there is not an environment of connectedness, and her attempts at mediation are not understood as being creative and beneficial. If the health care institution fostered a more open communication among health care providers as described above, then it could be directed toward the analysis of ethical dilemmas by use of a structured method as determined by the ethics committee.

If utilized in a sensitive manner so that both gendered discourses are expressed and valued, sexual difference as the basis of discourse opens the ethical analysis of health care relationships to some new and creative possibilities. Irigaray's work regarding feminine imaginary and sexual difference can be used to recognize the benefits for patient care in opening the traditional health care ethical analysis of dilemmas to include a feminine discourse.

Sexual Difference and Traditional Ethical Frameworks

Now that I have generally described how Irigaray's work on gendered discourse can be used in health care ethics, I will focus more specifically on how sexual difference and
gendered discourse have affected the traditional ethical frameworks of principlism, casuistry, and care. Throughout the previous chapters I have discussed the various components of health care relationships and how the ethical methodologies of principlism, casuistry, and care are related to them. I argued that part of the reason that principlism and casuistry have been insufficient in addressing health care relationships is the overwhelming influence of masculine discourse. I identified three areas of specific ethical concern related to the insufficiency of principlism and casuistry in addressing health care relationships that focused on how principles were interpreted, how they were applied, and how cases were chosen for ethical analysis. I will now describe specifically how the silencing of the feminine voice in health care has affected these ethical issues, using the end-of-life case study as an example. Further, I described how an unlimited ethic of care as described by Noddings could also be harmful when it did not take into account an interpretation of the body based on sexual difference. I will address the role of sexual difference, especially as realized via the maternal role phenomenologically. I will also discuss how feminine discourse can affect whether an ethic of care is considered an obligation or an ideal and how gendered discourse may affect how health care providers invoke an ethic of care.

**Principlism and Casuistry and Gendered Discourse**

Since both principlism and casuistry include some of the same interpretive concerns that have been related to their being derived from masculine discourse, I will address both of these frameworks together. In a previous chapter I delineated the limitations of these
ethical methodologies in analyzing health care relationships as being related to how they base the interpretation of principles on role obligations, how principles have been narrowly applied in ethical situations, and how the choice of cases to study has been limited. Using the end-of-life case as an example I will discuss how the use of gendered discourse by health providers affects these specific limitations and how a discourse including sexual difference could enhance these traditional ethical analyses. I am not arguing against the use of principlism and casuistry in health care ethics; only against their use from a narrow perspective.

Principles derived from traditional interpretation of role obligations

As I have discussed in previous chapters, health care providers have obligations of beneficence\textsuperscript{10} to patients that have traditionally been derived from the roles of the caregivers. Beauchamp and Childress in Principles of Biomedical Ethics present principles as being derived from considered judgments in the common morality and medical tradition that form our starting point in this volume. For example, the principle of beneficence derives, in part, from long-standing, professional role obligations in medicine to provide medical benefits to patients (1994, 37 underlining mine).

They much later mention briefly that there is an "implicit assumption of beneficence that
exists in medical and health care professions” (1994, 269). They do not emphasize that all health care providers have obligations to patients. Since physicians who historically have been male were used as the prototype of obligations to patients, as indicated in Beauchamp’s and Childress’ statement above, the result is that the obligations of nonphysician health care providers have been overlooked or have been prioritized as less important than those of physicians. This hierarchicalization has occurred as the principles of health care have been derived primarily from the obligations of physicians, leaving the obligations of the nonphysician health care providers either not discussed or presented only as secondary to the obligations of physicians.

Although nurses and physical therapists have similar general obligations of beneficence to patients as those of physicians, these obligations of nonphysician health care providers are not clearly specified by Beauchamp and Childress. This allows for the misperception that only physicians have obligations to patients. If this oversight is discussed by a voice from within the feminine discourse of nursing or physical therapy, the obligations of these "other" or "allied" health care providers remain on the margins of discussion about "medical" ethics". However, using Irigaray’s method of mimesis, the above words of Beauchamp and Childress are restated but with some changes and additions to emphasize the limitations of the text as it is written from the traditional masculine perspective. The following is a mimetic reading of Beauchamp’s and Childress’ description of how principles are derived from obligations.
The principle of beneficence derives, in part, from long-standing, professional role obligations of physicians who have the sole responsibility for providing care for patients in the health care setting.

Like Irigaray, I do not write this to elaborate on Beauchamp’s and Childress’ narrow description of beneficence; rather, to undermine it by illustrating how an omission can have consequences. By not including nonphysician health care providers in their descriptions of beneficence, Beauchamp’s and Childress’ words can be interpreted as meaning that only physicians have obligations to others in health care.

Since Beauchamp and Childress occasionally refer to nurses in their book and include a section on nursing’s conflicts regarding fidelity with physicians, they do not completely overlook nonphysician health care providers. However, while they have "hinted at an interdisciplinary account of biomedical ethics" (40), Beauchamp and Childress continue to describe ethics from the perspective of the physician. While they note a study that found that more nurses than physicians had ever perceived an ethical conflict between nurses and physicians, they attribute the difference in perception to the working relationship in which nurses carry out the orders of physicians and thus "often experience the problems that arise from medical decisions more immediately than physicians" (437). I agree with their analysis that nurses perceive conflicts, but I argue that the issue extends to the deeper level of gendered discourse.
Perhaps Beauchamp and Childress would argue that they mean to include appropriate health care providers under the heading of "medical," but that would be an example of silencing voices by the use of neutral language. It would be similar to claiming that all persons should be considered under a neutral "he." It is obvious that health care institutions could not function without nurses and physical therapists providing ongoing care for patients. By not including these health care providers who are predominately female, there remains an emphasis on the obligations of the male-dominated medical profession. In order to identify gaps left by a traditional masculine discourse, there must be a sensitivity to places of silence, where the female voice is being silenced. By sensing in this traditional text on health care ethics the subtle signals that something is missing, it becomes possible to allow the feminine imaginary to emerge so that the "other" voices could be heard.

The quality of patient care can be negatively affected when certain voices are prohibited from entering into ethical discussions. The narrow interpretation of the principle of beneficence by a masculine discourse of indifference can result in specific voices being excluded from a participation in the decision-making process regarding patient care. As in the end-of-life case study, the nurse and physical therapist had some important information that the patient had given them on prior admissions that did not become part of the decision-making process. The information was not recorded in the medical record possibly due to the interpretation by these health care providers that information obtained regarding an emotional aspect of patient care would not be appropriate in the medical
record. If the information was not written because of that interpretation, then the voices of the nurses and physical therapists were missing from the decision-making process because of institutional and environmental factors that promoted the use of only a masculine discourse in the medical record. Part of their roles in health care involves gathering information and relaying it to the appropriate person, especially the physician. The physician did not utilize the information that the nurse provided him regarding the patient’s wishes about limiting end-of-life information. Perhaps if Ms. Stone had written the information in the chart, Dr. Peel would have seen it as the familiar masculine discourse, but since it was not written, it remained in the fluid verbal form of feminine discourse. Using a traditional ethical analysis, the ethical issue in this case is the physician’s not respecting the autonomy of the patient to make decisions about his health care. When gendered discourse is included in the analysis, the relationship between the physician and the nurse involving the interpretation of the nurses’ obligation to the patient becomes another ethical concern.

When Nurse Stone attempted to provide Dr. Peel with the information about the patient’s preferences, the physician responded as if the nurse’s only obligation involved following the physician’s orders. Feminine discourse can be distinguished when Ms. Stone recognized that her obligation of beneficence to the patient involved trying to follow his wishes, and feminine discourse is apparent when she interpreted her role in patient care as one of mediation between the patient and physician. Ms. Stone may have recognized that there was more she should do on behalf of the patient as her imaginary emerged.
She expressed her concerns to Dr. Peel based on her interpretation of the obligation of beneficence, but he responded with a different interpretation that placed the physician’s interpretation in a hierarchically superior position that would take priority over the nurse’s position. Even though Ms. Stone had information about Mr. Green that may have made a difference in the decision about his care, Dr. Peel silenced her voice when he did not recognize that the nurse also had obligations to the patient. The physician eliminated the nurses’ voice from the deliberation by having her physically removed from the nursing unit. Because both health care providers interpreted their own obligations from a different perspective, their derivation of the principle of beneficence was then premised on different assumptions. These assumptions were grounded in their roles that phenomenologically have been related to gendered discourse.

**The application of principles**

The second factor that I discussed in a previous chapter that relates to the inadequacy of principlism and casuistry to address ethical issues associated with health care relationships involves how principles are applied in ethical dilemmas. Since the way that principles are interpreted is influenced by the discourse associated with the person interpreting the principle, then how that principle is used would also be affected by the gender of the discourse of the person invoking the principle. In the end-of-life case both the physician and the nurse invoke the principle of beneficence based on interpretations of their obligations to act to benefit the patient, but the principles are used in different manners. The physician’s interpretation of beneficence is to help the patient by using
life-sustaining treatments. The nurse's interpretation of beneficence would entail withholding or limiting the use of the ventilator. In determining how to apply the principle of beneficence the nurse and the physician had to choose certain circumstances of the case upon which to make their decisions. I will use Irigaray's work on sexual difference to discuss how gendered discourse is related to which circumstances they chose and how they assigned weight to these circumstances.

In health care when an ethical issue is being considered, certain choices must be made as to what aspects of the situation should be taken into consideration. Returning to the end-of-life case, the nurse and physician chose different circumstances upon which to base a decision regarding treatment for Mr. Green. The physician who was educated and now practices within an environment dominated by a masculine discourse, chose circumstances reflective of those environments. In order to decide whether to continue to order life-sustaining treatments for this patient, Dr. Peel considered the standard of care for similar patients in this situation. He decided that based on his obligation to benefit the patient, he should continue trying to extend the patient's life. Invoking a normative standard as part of his decision-making process would be considered appropriate medical care. By selecting criteria based on established guidelines, he chose circumstances commensurate with a masculine discourse that is associated with rigidity and stability. Dr. Peel chose to make his decision based on preset criteria that have been used by other physicians in similar cases. Another circumstance that is critical to Dr. Peel's decision-making is the fact that Mr. Green did not have an advance directive. He
based his decision upon his legal right to make the medical decision for the patient since the patient’s family asked him to do so. By choosing this circumstance of the case, he based his decision upon laws that were reflective of masculine discourse. He also invoked his legal and institutional role as sole decision-maker for the patient, which can be associated with Irigaray’s interpretation of masculine discourse as being singular, static, and a closed system\textsuperscript{13}.

While Dr. Peel’s choice of circumstances reveals that he is concerned about the patient’s physical and medical condition, there is no evidence that he considered circumstances of Mr. Green’s situation that would regard him as an individual. The circumstances that Nurse Stone chose to use in her application of the principle of beneficence were accumulated over time and reflect an ongoing relationship with the patient and family. By referring to Mr. Green’s and his family’s earlier conversations, Ms. Stone used circumstances that reflected the fluidity of feminine discourse. She also used a language reflective of a dynamic feminine discourse when she admitted that the treatments of hydration, nutrition, and dialysis had been of concern to her, but that she had waited to voice her opinion until the treatments had progressed to a point that they clearly violated Mr. Green’s wishes of not wanting to be separated from his family. The fact that she spoke on behalf of her patient, rather than remaining silent as the rest of the staff did, is indication that she received signals via her feminine imaginary that alerted her to an ethical dilemma. Although she seemed to recognize that the interventions of artificial hydration and nutrition and dialysis also violated the patients wishes, she may have
waited to act on behalf of the patient due to the environment of health care in which
dissension with the physician is not promoted. She may have had a struggle between her
position in the institution that reflects masculine discourse and her feminine imaginary
that alerted her to other possibilities for Mr. Green. I can only postulate what her
motives were since the case does not explain why she waited to act. If she had not
allowed those signals to become conscious and enable her to convert them into discourse,
the patient would have been transferred to the ICU without discussion14.
She attempted to have her voice heard in an effort to apply the principle of beneficence
from a different perspective. Ms. Stone believed that placing Mr. Green on a ventilator
and separating him from his family wronged him by not respecting his autonomy. She
was also concerned that the patient would be harmed physically due to the uncomfortable
and often frightening experience of being connected to a ventilator and emotionally
because he had not wanted to be separated from his family. Ms. Stone’s interpretation
of beneficence involved acting in a way to try to benefit her patient so that he could die
as he had requested. Her discourse reflects the multiplicity of feminine imaginary in
trying to recommend various alternate options for her patient.

The use of principlism without the consideration of gendered discourse, then, maintains
it in the realm of masculine discourse. By continuing to use principlism in its traditional
manner, as a mediation of conflicting principles, without delving into the discourse of
those who are invoking the principles, it remains, as Irigaray says, within sexual
indifference. While Beauchamp and Childress have strived to make principlism less rigid
and more responsive to the particular situations involved in an ethical dilemma by the use of specifying and balancing, they failed to address how specification and balancing could be affected by gendered discourse. Therefore limitations related to the interpretation and application of the principles remain inherent in principism. Specification and balancing enhance the way in which principles can be applied, but they are also bound by the discourse of the person invoking them. The specific aspects or circumstances of any situation chosen as important and relevant to be used in specification and balancing are determined by the parties involved in the ethical dilemma. By adding the particular circumstances of a case, there is more opportunity to make a decision based on a patient’s desires. As can be seen in the case, the parties in an ethical dilemma may not choose the same circumstances to consider in a case, nor may all of the circumstances in the case be considered, nor may they be given the same importance by different people.

From an Irigarayan point of view, specification and balancing could be interpreted as glimpses of a feminine discourse buried within the masculine discourse of health care. Since specification and balancing involve taking into consideration variables that may be evolving, such as the patient’s or family’s wishes, they represent the type of fluid and dynamic interactions that feminine discourse fosters. However, the masculine discourse of health care has a firm control over the decision-making process, based on historical and institutional authority granted to physicians, and has not historically encouraged additional voices to enter into the process. In the case study Nurse Stone discussed
circumstances of the case that were grounded in feminine discourse, but Dr. Peel was unwilling to listen to her due to being influenced by health care’s masculine discourse, a discourse that fosters hierarchies. Specification and balancing could provide a means for more circumstances and a greater multiplicity of voices and interpretations that could be considered in making decisions for patients. This possibility could occur if there were more acceptance in health care for the discourses of both genders.

In the case study the nurse and physical therapist are potentially in positions to help mediate between the patient’s wishes and the physician’s decision regarding end-of-life care for the patient. These nonphysician health care providers could function as intermediaries who could contribute ongoing and relevant information to the physician, but in the masculine discourse of health care the physician is established as the subject who decides and directs all aspects of a patient’s care without allowing the "object to speak." In this case even when there are several witnesses to Mr. Green’s statements regarding his end-of-life wishes, the masculine discourse of health care has the most influence regarding the patient’s care.

Choosing cases

Another concern about the feminine voice being silenced with respect to patient care involves how cases are chosen to be studied for their ethical considerations. From a broad perspective, nursing literature contains articles discussing the ethical ramifications of the relationship between nurses and physicians, often related to nurses being prohibited
from making patient care judgments that they deem appropriate for nursing. These concerns are often marginalized or dismissed as being unimportant by physicians. In fact these types of interprofessional relationship issues have not been addressed by physicians. One of the reasons that cases related to interprofessional relationship dilemmas have not been openly discussed can be related to gendered discourse, which I will explain in relation to the case.

When the selection of cases is considered on a more individual basis, nurses particularly have problems getting their voices heard. As in the case, it is common in hospitals that have ethics committees for a physician to be the chair or co-chair of the committee. Although not based on empirical studies, but rather on anecdotal information acquired from years of service on hospital ethics committees and from years of interaction with hospital ethics committee members, most ethical questions in the hospital setting are directed to the physician chair of the committee. Even if there is a nurse or patient representative as co-chair, that person often serves only in an administrative capacity. Therefore, the physician acts as the gatekeeper to the committee and has the authority to determine what is considered an "ethical" issue that the committee will discuss. While it is difficult to quantify how often requests for ethics consultations are denied, nurses often relate stories of having been told that their concerns were not of an appropriate nature to be discussed at an ethics committee.

There are ethical issues related to whether Mr. Green's case is chosen to be presented
to the ethics committee for discussion including whether Ms. Stone had been treated fairly by the chair of the ethics committee. However, if we look at the more basic level of discourse, it can be seen that there are elements related to gendered discourse. Because Dr. Jones, the chair of the ethics committee, is also guided by the same masculine discourse as Dr. Peel, he may not see that there is an ethical consideration since he would rely upon the masculine discourse of legal and institutional guidelines for his decision. As he points out to Ms. Stone, the physician has the legal responsibility to make the decisions for the patient when there is no advance directive and the family asks him to do so. Further, he would agree with Dr. Peel that under the traditional institutional hierarchical arrangement, Dr. Peel should be the sole decision-maker. Therefore, his response to Nurse Stone is grounded in a masculine discourse as evidenced by his reliance on guidelines and rules. Since Nurse Stone speaks to Dr. Jones from her perspective based on feminine discourse in which fluidity and multiplicity play significant roles, Dr. Jones may not understand her concerns for the patient based on her interpretation of her obligation and her position as mediator for Mr. Green. Since the ethics committee is an outgrowth of the institution of health care and is often dominated by physicians, it is therefore influenced by a masculine discourse. Efforts are often made to insure against a domination of the committee by one particular group by having a multidisciplinary membership, including non-health care community members. However, when a physician is in the position of gatekeeper, there can be a limitation on what cases are chosen to be presented to the committee.
From an Irigarayan perspective, we can search texts and discourse for those gaps and silences to try to identify places where the feminine voice has been repressed. Identifying how women's voices have been silenced by the system of health care is difficult and requires being able to be sensitive to subtle signs that something is lacking. For example, in the case Dr. Peel would have had to recognize that there could be other voices who might have different perspectives regarding Mr. Green's case. If he had been sensitive to the possibility that there could be other circumstances to consider rather than only those based on rigid guidelines, he might have made a different decision based on a discourse that would permit sexual difference to play a role. While it is difficult to hear the feminine voice in silences, Irigaray has alerted us to the infinite possibilities if we are sensitive to the feminine imaginary. If health care became more open to an unfamiliar feminine discourse, more creative opportunities for patient care could be considered.

**Noddings' Ethic of Care and Sexual Difference**

Just as principlism and casuistry could more thoroughly address situations involving relationships in health care if they included a greater sensitivity to sexual difference, an ethic of care could also become more useful in decision-making if it broadened its basis of interpretation by recognizing the importance of sexual difference. Although an ethic of care has traditionally been described in feminist literature, Noddings' description of this ethic does not take into account sexual difference. In fact, her description of care continues to reinforce a masculine discourse in which the one-caring is a reflection in the
mirror of the same. As I have described, Noddings’ work can be interpreted as dangerous or detrimental to those in the health care field who are traditionally in the positions of directly caring-for or caring-about patients. I will critique her description of care as lacking a sufficient recognition of sexual difference and gendered discourse. Using the case study as an example, I will discuss how masculine discourse tends to support caring-for as an obligation rather then allowing caring-about as an ideal. Further, Noddings’ use of the maternal role as the paradigm for caring also will be critiqued for its promulgation of sexual indifference.

Caring-for and caring-about

An ethic of care as I described previously involves a component of caring-for, caring-about, or both. I will explain how Irigaray’s interpretation of sexual difference can be associated with these aspects of care, and further how patient care may be affected when gendered discourse is considered in relation to caring-for and caring-about. In a previous chapter I described caring-for as the minimal obligation owed patients to provide adequate health care for their needs and caring-about as an ideal that involves an emotional connection to patients.

Irigaray’s work on sexual difference would preclude stating that the discourses of caring-for or caring-about could be separated definitely by gender since that would be using her work to maintain distance rather than the awareness of interconnectedness that her discussion of sexual difference promotes. However, caring-about can be associated with
many of the characteristics that Irigaray associates with the interpretation of the female body, and thus appears to be grounded more in feminine discourse. Caring-about can be described in the Irigarayan terms of fluidity and intermediacy. In order for caring-about to occur with a resulting emotional connection established between patients and health care providers or among providers, there must be an overcoming of boundaries. In order to address a person's emotional and psychological needs, in addition to the physical needs, there is usually a greater sharing of information related to personal matters. As I have already discussed, caring-about does not necessarily require reciprocity, but its fluid and unbounded nature would leave the opportunity for reciprocity or a connection to be formed. If a person shares personal information, that does not obligate the other person to respond to it, but it may provide an opening for a future connection to be made.

Caring-for, as a minimal obligation, fits the mode of masculine discourse as it relates to what is expected for all persons to receive adequate health care. In order for health care providers to know if they are providing the obligatory caring-for a patient, there are guidelines, protocols, or standards of care to guide them in the provision of health care. Even though there are variations in standards of care and there may be multiple choices of treatments available to care-for a patient, caring-for a patient can be described in terms of treatments or techniques that are required as a basis for health care. Caring-for can be more often associated with masculine discourse, grounded in sameness and rigidity, since it identifies specific courses of action that may be chosen on behalf of the patient.
Caring-about is less easily identified since it involves an emotional aspect of a specific patient’s situation.

In the end-of-life case, Mr. Green spoke on several occasions with various staff members regarding his fears about living "like a vegetable" and his preferences about limiting end-of-life treatments when he could no longer interact with his family. Nurse Stone had developed more than just a clinical interest in the patient over the time that she had taken care of him. She felt that his care required more than just providing the minimal standard of care. The patient had shared much personal information with her that she believed should be used in the decision-making process. During the time that Ms. Stone had been caring-for Mr. Green, an emotional connection had been made. Ms. Stone was able to recognize the importance of this connection, which may have led her via her feminine imaginary to intervene with Dr. Peel.

Because Dr. Peel had not developed a relationship with Mr. Green beyond the obligatory caring-for, he was unable to recognize the importance of allowing additional non-medical information or other voices to affect his decision. Mr. Green’s physical needs were being cared-for by the physician based on what Dr. Peel recognized as the standard of care, and thus fulfilling what was minimally required as an obligation. Dr. Peel did not participate in the ideal of caring-about the patient from an emotional perspective. His motivation for this is unknown; whether he did not recognize the feminine discourse of caring-about or marginalized it as unimportant. Since the psychosocial aspects of patient
care are often left to others than the physician, the physician may not have been sensitized to the relevance of this aspect of patient care for the overall well-being of the patient and the family. Therefore, silencing the voices of those who care-about the patient placed the care of the patient at a minimal level required by obligation.

Since I have described how persons cannot be forced to emotionally respond to patients or other health care providers, caring-for can only be the minimal obligation required. However, caring-about patients should be an ideal for which health care providers could strive when it is appropriate. I have discussed some of the limitations on caring-about that are necessary to make it less self-sacrificial and dangerous for those health care providers who choose to participate in caring-about their patients. As I discussed in a previous chapter, self-sacrifice is particularly dangerous in health care.

Care, as described by Noddings, is unlimited and other-directed, thus placing the person caring-about at risk of becoming overwhelmed by the needs of others. Even though providing care-for others is the minimal obligation of health care providers, care of the self is primary to caring-about others. Especially since caring-about is being associated with feminine discourse, women particularly must avoid an ethical theory that would place them in jeopardy of displacing the self in favor of the other. Irigaray’s work does not support using a feminine discourse if it is detrimental to Ms. Stone. In the case study it is difficult to determine whether Nurse Stone sacrificed herself for her patient. Although she was punished by being transferred to a different nursing unit, Ms. Stone
may have decided that by advocating for her patient, she was actually strengthening herself. If feminine discourse were more readily recognized and respected, then Ms. Stone would be able to participate in decision-making about patient care without fear of reprisal.

Noddings’ interpretation of the maternal role

Since Noddings uses the model of the mother/child as the paradigm for her ethic of care, she is promoting an ethic of indifference similar to Freud. Noddings claims that care is based on woman’s procreative function and role as mother as the one who unconditionally provides care for the dependent other with no possibility of ethically withdrawing that care. If this interpretation of an ethic of care, based on woman’s maternal function is used, men in health care may find it difficult to understand the significance and relevance of an ethic of care. Since health care is provided by both men and women, an ethical theory must be relevant to both genders. Even though Noddings claims that she does not exclude men, she refers to her work as a “feminine ethic” and says:

It should be clear that my description of an ethic of caring as a feminine ethic does not imply a claim to speak for all women nor to exclude men. As we shall see in the next chapter, there is reason to believe that women are somewhat better equipped for caring than men are. This is partly a result of the construction of psychological deep structures in the mother-child relationship (1984, 97).
This appears to be a contradictory statement in which she appears to exclude men from her description of care even though she claims not to. Irigaray’s technique of mimesis could be used here to illustrate how Noddings’ work can be interpreted as promoting indifference. Her passage can be mimetically interpreted as:

While my description of an ethic of care does not speak for all women nor exclude men, women are somewhat better equipped for caring than men, due to their inherent understanding of their maternal roles. The difference in the construction of psychological deep structures between men and women makes each of them better prepared for certain activities.

When Noddings claims that women are more naturally inclined to care, she is using an essentialist argument that historically has been harmful to women\textsuperscript{15}. As in my mimetic restatement, when essentialism is used to promote a position of women, it can also be inverted into an argument claiming the superiority of men in specific areas\textsuperscript{16}. Rather, Irigaray’s phenomenological interpretation of the maternal role relates to a role of mediation in forming a new creation. Irigaray does not focus on woman’s specific role in procreation nor on her function as mother. When Irigaray interprets fecundity, it is not confined within the boundaries of one gender. If one can recognize a feminine discourse that engenders interpretations involving growth and becoming, the maternal role can become an interpreted quality that could be utilized positively in health care ethics with significance for both genders.
The association of woman and the role of mother can be seen in the health care environment, since many of the tasks performed by women are of an intimate, nurturing nature. These tasks have been associated with the care that a mother provides a child at home; therefore once again woman is associated with her supposedly innate natural maternal abilities. Ironically, many of the tasks performed by physicians are also of an intimate nature, yet physicians tend to be valued more for their interpretive and decision-making roles rather than for the hands-on care provided for patients\(^{17}\). This difference in the interpretation of the roles in health care translates into ongoing issues with ethical considerations.

Irigaray provides a means to re-value the role of women in order to counter the masculine discourse of indifference that has placed them in an inferior hierarchical position in health care. Irigaray's interpretation of sexual difference provides a basis for the maternal role to be associated positively with feminine discourse rather than the one presented by Noddings. Whereas Noddings focuses on the caring function of the mother for the child, Irigaray uses a broader and less literal interpretation of maternity. Instead of using the actual functions that a mother performs as in Noddings' ethic of care, Irigaray interprets the maternal role as an intermediate state in which woman's role is participative in the becoming of new life. It represents the fluid aspect of feminine discourse in which growth and fecundity are important. This is unlike masculine discourse that values sameness and stability. Therefore, Irigaray's interpretation of the female maternal role places feminine discourse as part of a process that enhances its
participants' growth and possibility for development into something new.

Rather than an ethic of care being grounded in a mother's natural care for her child, an ethic of care suitable for all persons in health care would be based on an ethic that could promote the development of an emotional regard for patients and other health care providers. An ethic that includes care as a component would function not only as a minimal level of providing obligatory care-for a patient, but would also allow the one-caring to become a mediator in recognizing the potential significance of the emotional component of health care. In health care this already occurs by many different persons, not just female providers of health care. Often in patient care situations, physicians recognize the importance of using psychologists, chaplains, or social workers to address different aspects of the patient's situation. Irigaray's use of sexual difference in her interpretation of the maternal role is more appropriate for all providers of health care. This interpretation allows care to be a component of health care ethics, in addition to principlism and casuistry, to help bring patients and providers into relationships that include the potential for becoming more than impersonal clinical relationships. However, it is imperative that limitations also be included as guides to relationships that include care. As opposed to Noddings' construction of a "feminine" ethic of care that promotes an engrossment with the other, there must be limitations to protect the person from losing the self in the other.

Although Noddings' discussion of an ethic of care appears to have elements of feminine
discourse embedded within it, those aspects of her work are overshadowed by the masculine discourse of sameness. While at first Noddings’ ethical ideal as that which "connects me naturally to the other, reconnects me through the other to myself" would appear as an example of Irigaray’s interpretation of feminine discourse since it involves forming a connection, it does so only by way of the other and is more influenced by a masculine discourse of reflection and sameness rather than feminine discourse that promotes multiplicity and diversity (1984, 49). Once again, the self is constructed as a mirror image of another through which one is related. By establishing this reflection of another image as the "ideal self," the feminine imaginary is caught within the circle of indifference and cannot be expressed in discourse. Further, Noddings says that an obligation of caring develops as the natural impulse to care becomes an "impulse to act on behalf of the present other. We are engrossed in the other" (1984, 83). While there is a hint of a feminine discourse in the crevices of this obligation based on relatedness, it is expressed in the masculine discourse of sameness. Noddings has provided us with an ethic that may have served as a stimulus to the feminine imaginary as something different from the traditional masculine ethical methodologies, but she was unable to escape the discourse of indifference and sameness that promotes the one-caring becoming engrossed in the other without option of withdrawal.

Although I have critiqued Noddings’ construction of care, her emphasis on the goodness of relatedness is suggestive of Irigaray’s descriptors of fluidity, multiplicity, and intermediacy as qualities of feminine discourse based on sexual difference. Noddings
clearly recognizes that relationships that have connections based on interdependence include an ethical component because one person offers an emotional connection to another. Irigaray describes this relationship in terms of intersubjectivity, but as opposed to Noddings who continues to allow woman to be placed as an object, Irigaray promotes the construction of two subjects who interact without having a reflection of an other. Since intersubjectivity as Irigaray describes it would promote growth and becoming, it would be associated with her phenomenological description of woman's maternal function as one of intermediacy. Therefore, a health care provider who chooses to offer more to a patient than the minimal caring-for could be in an intermediate position in transforming an obligation into an ideal of caring-about. Health care providers can choose to participate in a relationship involving caring-about but they are not required to do so.

It is unclear in the case study when Ms. Stone's obligation of caring-for evolved into caring-about. As reflective of a feminine discourse, this transformation would occur gradually and may not involve a distinct or identifiable moment of change. Just as feminine discourse has been described as dynamic and fluid, the development of a caring relationship that involves an emotional component would occur over a period of time as the patient and the provider develop a more intimate relationship. As Mr. Green expressed his wishes about his care at the end-of-life, Ms. Stone's response to him evolved from one based on an obligation of caring-for his physical needs to a more emotional caring-about him as an individual person. She continued to care-for Mr. Green, but the connection that she made with him was based on her becoming aware of
his specific family and home situation and how he felt about not being able to interact
with his family. As she learned more about his desires, Ms. Stone was better able to
discuss his preferences with Dr. Peel. From his response to Ms. Stone about providing
Mr. Green the standard of care, it appears that Dr. Peel viewed his relationship with Mr.
Green as one of an obligation of caring—for the patient’s medical needs.

One of the reasons that Ms. Stone and Dr. Peel were unable to agree upon a course of
action for the patient could be that neither of them recognized that they were speaking
from different discourses. Since the institution of health care functions within an
environment dominated by masculine discourse, and the sole decision-making authority
is assigned to the physician, the feminine discourse of caring-about used by the nurse in
this case was silenced. Ms. Stone was denied the position of intermediary, and the
resulting care of Mr. Green was to treat him at a minimal obligatory level of caring—for.

Consequences of Ethical Analysis

and Sexual Difference

There are consequences to patients, nonphysician health care providers, and physicians
that are related to the recognition of the role of sexual difference in ethical decision-
making. Using the case study as an example, I will discuss the possibility of harm to the
patient when only a masculine discourse is considered. There can be harmful
repercussions in patient care when there is a decrease in cooperation among health care
providers that could arise from an inability to recognize different discourses. There are
consequences to nonphysician providers when their voices are eliminated from the
decision-making process, including limitations from being able to utilize their knowledge
and expertise on behalf of their patients. When different discourses are used and
conflicts arise, the nonphysician may be treated with disrespect. Physicians may also
suffer harmful consequences if they preclude valuable patient information from entering
into the decision-making process. Physicians can also become isolated in the health care
environment when they refuse to listen to other voices. Their interpretation of
beneficence could be based on inadequate information, thus diminishing the ethical
significance of their decisions.

Possible Effects of Gendered Discourse on Patients

Patients can be affected by the use of gendered discourse in decision-making. In the end-
of-life case study Mr. Green was treated with life-sustaining modalities that he had not
desired and could be considered harmful.

I use "harm" in a general sense as Beauchamp and Childress describe it to mean
"thwarting, defeating, or setting back the interests of one party by causes that include
self-harming conditions as well as the (intentional or unintentional) actions of another
party" (1994, 193). In the case, Mr. Green’s right of autonomy was violated, resulting
in a wrong to him. However, I will use the more general term of harm since I will refer
to consequences to the patient other than related to his rights. Mr. Green suffered
physical and emotional harm from having uncomfortable invasive procedures performed
to him that he had not wanted when each of the life-sustaining treatments were begun, especially the ventilator.

As I have already discussed, this case involves more than conflicting principles. The patient received treatments that he did not desire, in part because the physician did not recognize or allow a feminine discourse to become a part of the decision-making process. The patient was also indirectly harmed by the silencing of the feminine voice that resulted in less communication among the health care providers regarding the care of the patient. Multiple health care providers are required for patients to receive health care in an institutional setting. A foundation for effective communication about patients rests upon an open exchange of necessary information. Communication between Ms. Stone and Dr. Peel was affected when Ms. Stone did not document Mr. Green's wishes in the medical record. This hospital evidently did not require nonphysicians to record the emotional component of their interactions with patients in the chart. On the other hand, Ms. Stone could have interpreted that information obtained during an emotional connection would not be appropriate in a medical record, or she could have learned from experience that the physician would not read her comments so she only wrote what she considered objective and necessary information.¹⁸

Most of the communication that occurs between health care providers is grounded in a masculine discourse of laboratory reports or physical changes that can be described objectively. The problem arises when one provider tries to interject a different discourse
based on fluid and dynamic information that might have been received during a patient
encounter with an emotional component. This type of information has the qualities of
feminine discourse. If health care providers, especially nurses, physical therapists, and
physicians are to work together interdependently to provide optimal care for patients,
they should be able to recognize the benefits of using both masculine and feminine
discourse.

A feminine discourse would promote the exchange of ideas among those who were
responsible for the patient, including the family and providers. In a health care
environment in which the voices of the whole health care team are not only heard but
also sought, a decision could be made utilizing patient information that includes the
specific circumstances of that patient. In the case, if Dr. Peel had been able to recognize
that Ms. Stone had valuable information regarding the patient’s wishes even though it
was delivered within a feminine discourse, more cooperation among the staff could have
been fostered. In an environment of cooperation, other staff members would see that if
they had information about a patient, that they should try to convey it to the physician
who would appreciate having all the pertinent information so that an appropriate patient
care decision could be made.

This element of cooperation in health care is related to how health care professions
developed historically. I will argue that as feminine discourse plays a greater role in
the relationship, there is more cooperation among health care providers. Health care
defies being confined within a static or rigid masculine discourse, and an example of this is the fluid nature of the patient/provider relationship that occurs within an environment of health care in constant change. Health care is a dynamic environment in which multiple health care providers take care of multiple patients often with multiple illnesses. The patient/provider relationship reflects this dynamic environment since it involves an aspect of uncertainty due to the differences in patients' physiological states and their different responses to various interventions. Further, patients are in a vulnerable position, and they must trust that the providers of health care will act in their best interest. All of these factors - the multiplicity of the situation, the uncertain nature of health care, and the vulnerability of the patient - fit with Irigaray's interpretation of feminine discourse. It is a system that performs best when there is a constant flow of information and communication between the patient and the provider and among providers.

When masculine discourse of a single authoritative voice enters this environment, it interrupts the free-flow of communication. This may be necessary in situations in which the patient is critically ill and efficiency is more important than the benefits of multiple voices. It may also be necessary in those rare situations in which the patient makes it clear that the physician is to be the sole decision-maker and the patient waives the right of autonomy. In many situations, an authoritative voice that silences all other voices would have a detrimental effect on the care of the patient. The voices of nonphysician caregivers can also be muted by the static environment that promotes a hierarchical and
authoritative arrangement of voices. When masculine discourse is reflected in this environment, nurses and physical therapists learn to function within the institution even when their voices are restrained. However, when the patient and health care provider are relating in a fluid manner, there appears to be a greater opportunity for communication of the patient's wishes, especially if the patient has expressed them to someone other than a physician. When this environment of openness changes to one closed within the boundaries of one voice, there is less opportunity for cooperation among those providing care to the patient since only one voice is recognized as having significance.

In the case, Mr. Green's relationship with the staff appears to be open and fluid as evidenced by his repeated comments regarding his end-of-life preferences. Care for Mr. Green is provided in an environment in which his treatments evolve in response to his changing condition. However, when Ms. Stone speaks to Dr. Peel and tries to convey the patient's wishes, Dr. Peel responds in the masculine discourse based on rigidity and rules. Instead of an environment fostering cooperation and communication that would have the feminine dynamic qualities of fluidity and multiplicity, the masculine discourse of closure and singularity predominated. Perhaps if Ms. Stone had attempted to translate the patient's preferences into writing, which would be a more stable form, Dr. Peel may have been able to relate to it as a more masculine discourse. In this case interprofessional communication and cooperation not only ceased, but the nurse was physically removed from the environment that assured that feminine discourse would not
become a part of the decision-making process.

Although the patient/provider relationship shares many of the same characteristics as feminine discourse based on sexual difference, the interprofessional relationship has more characteristics of masculine discourse. In interprofessional relationships where authority and hierarchy are well-established, it may be more difficult for communication to be based on cooperation. Using an Irigarayan interpretation, a person in health care speaking with the voice of authority could be associated with the position of a subject who does not expect or allow the "other" who is in the position of object to speak. The gender of the person would not matter, since it is the use of one's authority that maintains a position of superiority in the hierarchy. The roles of nurses and physical therapists traditionally and historically developed from health care providers taking orders from physicians and carrying them out without question. The lines of communication were established based within the confines of the masculine discourse of reporting static information. When it is necessary for information that includes dynamic or interpreted information to be communicated back to the physician, the communication may be hindered by boundaries that have been historically erected. As nurses and physical therapists have grown in their areas of expertise, these boundaries separating them from physicians generally have not become more fluid.

Another example of how the roles of health care providers can be interpreted as representing gendered discourse by way of sexual difference is the traditional hands-on
tasks of the predominately female health professions. As Irigaray has stated, a feminine discourse can be associated with woman’s individual and collective experiences, and therefore the variety of experiences among persons and situations provides a depth to the texture of feminine discourse. Although there are occasions in health care in which a feminine discourse can be recognized, for example in nursing’s attention to the psychosocial aspects of patient care, which includes a multiplicity of factors associated with the physical and mental state of the patient, this aspect of the patient’s care has received little recognition of its importance. The specific diagnosis of the disease process, established by the physician, is the focal point of the patient’s care. While the primary disease process should receive the attention of the health care providers, the other factors that affect the patient’s life and the ability to recover successfully need to be addressed for the patient to receive optimal care.

There are physicians who welcome the input of nurses and physical therapists so that they can have as much information about their patients as possible. Those occasions can be viewed as the crevices of health care in which a feminine discourse of cooperation can be glimpsed and the results of improved patient care can be witnessed. If more cooperative sharing of information had occurred in the case from both the nurse and the physician, at least the nurse would have been able to provide the information that she had received from the patient so that it could have been considered in the decision-making process. It is possible that the consequences for the patient could be changed by the inclusion of a feminine discourse that can be associated with the dynamic elements of
relationships. These dynamic elements - the multiple levels and roles of practitioners, the level of intimacy, and the public/private nature of health care - are significant in the patient/provider relationship.

Since many different persons with various levels of training and education form relationships with patients, a necessary amount of communication must occur in order for patient care to be performed. Although information has been exchanged in the health care institution, the environment that promotes the fluid and reciprocal exchange of information does not always appear to exist between physicians and nonphysician health care providers. The institution itself promotes a unilateral flow of information so that physicians who hold the hierarchically superior position usually control what information is considered important in decision-making. For example, a physical therapist may write extensive notes in the medical record in a specific and separate section of the medical record. The physician may not read those notes, but all providers who care-for patients read the physician’s progress notes. From an Irigarayan perspective, the relationship between physicians and other providers is dictated by a discourse of sameness, in which the physician is considered the norm and all others are only deficient reflections. The institution of health care does not function optimally when nonphysician health care providers relinquish their voices and allow themselves to become objects in reflective response to the physician’s subjectivity. Since the authoritative position of the physician is related to the masculine discourse of the system, it could be mediated for the benefit of the patient by the recognition of the value of feminine discourse as part of the
decision-making process. This is not an effort to replace the physician’s position in health care as the diagnostician who coordinates services for the patient, but rather a means to allowing multiple voices to participate in decision-making.

The quality of patient care can be affected by the dynamic elements of the level of intimacy and the public/private nature of health care, and these elements also are factors in interprofessional relationships. Since the intimate aspect of patient care relates to what is performed directly to the patient and usually involves personal contact, it would also mean that certain boundaries that are normally erected in society are crossed in health care. As the continuum moves from intimate to stranger and from private to public, the discourse changes from one individually oriented by the use of specific circumstances of the patient’s situation and thus most reflective of feminine discourse to one of masculine discourse that uses more general and broadly defined terms. For example, if a specific patient is being discussed, information regarding that patient’s individual status would be considered, including personal information such as the patient’s desires or the family situation. If a disease process is being discussed in general, personal information would not be applicable, and only a discourse in terms of generalities would be possible.

Feminine discourse that reflects sexual difference, especially the openness, multiplicity, and fluidity as interpreted by Irigaray, would also encourage communication unencumbered by boundaries or sameness. Feminine discourse, like that toward the intimate and private end of the continuum, would include the aspects of patient care that
are not generalized, but rather recognize the patient for the concrete differences that make the patient unique. Appropriate patient care cannot be provided by using only the masculine discourse established in the public arena, since each patient’s situation and circumstances would affect the care that the patient might receive. In the case study, if the physician had tried to incorporate the patient’s desires into the decision-making process, perhaps a different outcome would have been reached. Rather than considering Mr. Green’s desires before deciding how the patient would be treated, Dr. Peel made his decision based on his interpretation of his obligation of beneficence that he associated with prolonging the patient’s life. If the nurse had been allowed to fulfill an intermediate position of communicating the specific circumstances of the patient’s intimate conversations that were held at times when care was being provided in private situations, a feminine discourse including multiple voices of cooperation could have worked to the benefit of the patient.

Consequences to Nonphysician Health Care Providers

Related to Gendered Discourse

While the consequences involving the patient are the most important concerns regarding the insufficiency of traditional ethical methodologies to address ethical concerns that are associated with health care relationships, the nonphysician health care provider also may be subject to negative outcomes. I will discuss three aspects of how these health care providers are harmed when ethics does not adequately address the concerns involved in interprofessional relationships and the role that gendered discourse plays. First, because
their voices may be silenced, nonphysician health care providers are limited from being able to use the fullest extent of their knowledge and expertise, especially with regards to contributing to and participating in decisions about patient care. Second, since many of their functions are associated with the maternal role, many nonphysician health care providers have not been valued for the hands-on care that they provide to patients. Finally, I will discuss how the nonphysician health care providers are harmed when ethical concerns specific to them are overlooked by traditional ethics.

Loss of voice

As the institution of health care prioritizes the obligations of physicians over those of nurses and physical therapists, these nonphysician health care providers may be limited in their ability to fulfill their obligations in patient care whether directly or indirectly by being dismissed as irrelevant\textsuperscript{19}. It is important to delineate the difference between an individual physician forcing someone to violate an obligation, or even encouraging or allowing a violation of an obligation and how the discourse that is used affects how the obligations are interpreted. I am more concerned with how the interpretation of the roles of health care providers and the environment of the institution of health care foster the use of masculine discourse without the consideration that there might be other discourses relevant to the situation\textsuperscript{20}. When the multiple voices of other providers involved in the care of the patient are silenced, and when their roles are not interpreted as having obligations to patients, they cannot use their expertise in the care of the patient for which they have been held ethically and legally accountable. They are limited from using the
knowledge and expertise in the manner for which they were educated because the traditional discourse of health care has not recognized the value of difference that nonphysician health care providers represent.

In the case study, Ms. Stone was able to sense that the patient’s voice was missing from the decision-making process when others around her did not seem to notice. By engaging in a feminine discourse that encouraged fluidity and multiplicity and speaking as an intermediary on Mr. Green’s behalf, she attempted to fulfill her obligation to the patient that in this case meant that she would work on the patient’s behalf to try to convey his preference for a limitation of treatment. Her feminine discourse was rejected by Dr. Peel whose response was grounded in masculine discourse of singularity that reinforced his authoritative position. She was prevented from using her knowledge of this patient and her skills as a nurse in treating this patient.

Silencing the nurse’s voice can result in other possible consequences in this case. We do not know what happened to Ms. Stone after she was transferred to another nursing unit, but there are several possible reactions that she may have had and that I have witnessed after similar incidents have occurred to nonphysician health care providers whose voices have been silenced. Nothing may change in the way that Ms. Stone provides care for patients. She may continue to try to advocate for patients and try to make changes in the system. If she began to believe that only the physician’s voice was important in health care decision-making, she may have become reluctant to make
decisions, and thus she may have distanced herself from asserting her obligation to become involved in future patients’ well-being. In a future situation with a similar patient, she could relinquish her belief that nurses also have obligations of beneficence and succumb to the masculine discourse, thus fulfilling the tradition of the physician’s authority as primary. She may no longer attempt to participate actively in patient decision-making. Further, it is possible that she could carry her resentment over the way she was treated into other patients’ rooms and thus negatively affect the care of other patients. If she continues to believe that her obligation of beneficence is significant in patient care, she may find ways of manipulating patients or colleagues to achieve her goals.

While some nurses and physical therapists are able to continue striving to speak on behalf of their patients, others decide to leave the institution where their voices have been constrained, and the situation where they suffered disrespect. Many search for employment where their knowledge and expertise can be more fully used to benefit patients and choose to leave the place of employment or even the field of nursing altogether without taking further steps to try to change the situation. This is one way that the supremacy of masculine discourse has continued to flourish in health care. Nurses and physical therapists whose roles place them in positions of little authority within the institution of health care have had little opportunity to effect a change on the discourse that permeates interprofessional relationships.
In this case Ms. Stone not only lost her ability to speak on behalf of the patient but also was treated with disrespect by the physician. Although the nurse had developed a unique and important relationship with her patient, she was not respected for her attempt to convey specific patient-related information to the appropriate person, the physician. Her role as the intermediary between the patient and physician was not recognized by Dr. Peel. Applying Irigaray’s phenomenological approach, Ms. Stone was in an intermediate position and had an opportunity to form a connection between the patient and the physician so that information could be used for the benefit of the patient. The nurse represented a feminine discourse of multiple voices, but the physician did not recognize her discourse since it was different than the dominant masculine discourse of singularity and sameness.

Irigaray’s work has shown that woman’s voice has been historically usurped by the masculine discourse and used for its purposes. Irigaray claims that the exclusion of the feminine voice in philosophy has led to "rendering female desire aphasic and more generally atonic in all but its phallomorphic disguises, masquerades, and demands" (Sp 143). Not only has feminine discourse been silenced, but woman’s voice has been reinterpreted by masculine discourse to represent the message of sameness and singularity, such as in Noddings’ description of an ethic of care in which woman’s value is derived from her reflection in the other. There is evidence that woman has adapted to a phallocentric system by using the masculine discourse to her advantage whenever possible. By using the written word in the medical record, a nurse can attempt to
communicate in the accepted masculine discourse. In the "nurse/doctor game," a nurse would allow her voice to be usurped by the physician’s in order to achieve the nurse’s goals of appropriate patient care, thus fulfilling the obligation of beneficence to the patient. By continuing this type of relationship grounded in masculine discourse, nonphysician health care providers are participating in the silencing of their own voices in order to achieve their goals of patient care. Nurses, by willingly participating in this masquerade, have allowed the practice to become a part of what is considered normal in health care. As a result, when nurses, such as in the case, attempt to use a feminine discourse based on sexual difference, they are silenced because their voices have not been understood.

There has been a movement in health care to increase the cooperative nature of patient care by placing a greater emphasis on the role of the team in patient care. Nurses and physical therapists have taken active roles in promoting the benefit of teamwork for the patients. By virtue of their roles as hands-on caregivers who often act as intermediaries, these nonphysician providers recognize the value in the team approach that would allow multiple voices to be a part of patient care. The concept of teamwork resonates with feminine discourse since it promotes multiplicity. While there have been some changes in how care is provided, especially in the coordination of services, one of the results of this movement has been to emphasize the physician’s position as the "captain" of the team. Instead of using feminine discourse of multiplicity, many teams reverted to the masculine discourse of singularity as the physician often remained the sole decision-
maker. The system that was already established based on a masculine discourse of sameness and authority was incapable of responding adequately to a new discourse and therefore continued to be based on a hierarchical management of patients. While any team or group working toward a common goal needs a leader who will coordinate activities and encourage participation of the members, this role came to reflect the masculine discourse of authority in which the team leader maintained control of the activities of the team. "Team" members often were not respected for their knowledge and expertise as their voices made little difference in the decisions about patient care. A group that acknowledged a feminine discourse would value multiplicity and difference among the members of the group and would increase the number of voices that participated in patient care decision-making. Team members would acknowledge each other's areas of expertise and treat each other with respect so that each patient would receive the most appropriate care from each team member.

Collapse of self and other

One of the risks to nonphysician health care providers whose voices are often silenced by the dominant masculine discourse is that the self will be overcome by the discourse of the one in the authoritative position. If the self is overcome by the discourse of the other, then the self may never have an opportunity to hear a different discourse. If the self is only a reflection of the mirror image of another, then the self may be unable to recognize a feminine imaginary's signals.
An example of this can be seen in the case study. Only Ms. Stone spoke on behalf of Mr. Green. Others did not come forward as advocates for the patient. The other staff members do not say why they are willing to allow the physician's authority to override their voices so that their motivations are unknown and only possibilities can be constructed. They may be unable to withdraw from the masculine discourse that supports the hierarchical superiority of the physician and places the physician as the sole decision-maker for a number of reasons. They may not have recognized the possible positive outcomes for the patient represented by their positions of fluidity. They may not have recognized the value of multiplicity in patient care rather than singularity or that they could be mediators between the patient and the physician. Since the other staff members had not yet recognized the value of the qualities that their own bodies represented, then they continued to be locked within the discourse that acted to silence their own voices\textsuperscript{21}.

An ethic of care such as Noddings', which is embedded within a masculine discourse of sameness even as it tries to promote woman's qualities, maintains the self as a reflection of the other because it does not recognize the importance of how sexual difference can be interpreted. It is important for woman to be able to recognize her specificity through sexual difference so that she can maintain a unique self-awareness. In theories such as Lacan's in which woman develops as the mirror image of man, woman cannot see herself without the male face obscuring her own unique self image. When woman is placed as the deficient reflection of man, as often occurs in health care, she could potentially find herself in the service of the other without considering her own needs. An ethic of care
as described by Noddings increases the risk of obscuring the self as it promotes the one-caring to become engrossed in the other. Further harm is done when the one-caring is not authorized to withdraw care, as in Noddings’ work, which claims that the ethical relationship would be diminished if she did not remain as a part of the relationship. When the self and other collapse into one, the dangers of self-sacrifice appear. In order for the self not to be overcome and sacrificed in the service of another, it must be open to difference and not be absorbed in the mirror of sameness. Irigaray says:

How is this self to remain open into the present? Open enough? Still susceptible to the affect of the I. Closed and enveloped enough to make a self. Separate enough so that I can affect it and be affected by it. Close enough or approachable enough for affect to be possible. (E 62).

The self of sexual difference, as opposed to masculine indifference, is open and permeable to others, and is not closed off by the boundaries of sameness. This interpretation of the self can be exhibited by nurses in a hospital setting. They function within boundaries established by the hierarchical nature of the institution as they carry out the directions of the physicians who make the diagnoses. In the case study, Ms. Stone recognizes that her obligation to the patient requires her to speak in opposition to the physician on behalf of the patient. If a nurse allows a collapse of the self and other, and reflects only what the physician determines is appropriate, she relinquishes her subjectivity and sacrifices her self to the mirror image. If the nurse recognizes her
unique quality as an intermediary and establishes her self without reflection, but as someone with a different and important perspective, she may find her voice on behalf of the patient.

**Inability to recognize ethical concerns**

In the current health care system, ethical issues that involve the relationship between physicians and other health care providers often are unaddressed. They may not be recognized as ethical issues by those who are a part of the traditional environment dominated by masculine discourse. These issues are often ongoing and inconsistent dilemmas that affect only a segment of the health care providers and patients and are buried within the masculine discourse that is an inherent part of the problem. Further, those affected by these ethical issues are often so well integrated into the masculine discourse of the health care system that the hierarchical relationships in health care are considered the norm and do not generate ethical concerns. In order to recognize the potential ethical problems inherent in health care relationships, a person must be sensitized to a discourse other than the dominant masculine discourse. Without being able to understand the negative effects of health care relationships grounded in masculine discourse, there would be no recognition of the importance of addressing them.

Interprofessional relationships in health care often function as those between subjects and objects. Irigaray explains how this phallocentric relationship represses feminine subjectivity so that woman can only perform the role assigned to her by the subject of
masculine discourse. In health care this phenomenon can be witnessed if nonphysician health care providers become the objects that are manipulated by the subjects who are traditionally the physicians. The female voice in health care is often obscured if not silenced by the authority of the male physician. Woman, as object, becomes a thing, without her own will, and "quits her own ethical site" (E 199). Since woman has been described as the reflection of man, she may have difficulty accepting an ethical analysis that includes feminine discourse since she also has analyzed ethical issues using masculine discourse. Women, especially in health care professions, have not been encouraged to question their position in the hierarchy of health care providers. This could be addressed by an Irigarayan intersubjectivity in which a feminine discourse acknowledges the possibility of multiple subjects responding to each other.

In the case study, Ms. Stone began to speak as the subject to the physician. At first when treatments such as hydration, nutrition, and dialysis were being administered to Mr. Green she did not speak on behalf of the patient. Ms. Stone finally realized that there was an ethical issue involved in this patient’s care and began to speak as a subject.

**Consequences to Physicians**

When the physician does not have access to all of the information regarding a patient’s situation that could be useful in the decision-making process, the physician’s ability to provide optimal care is limited. Although the physician has the most authority and
control over decision-making in health care, the physician also can be a victim of the hierarchical arrangement in which the physician is placed in the superior position by masculine discourse. There is a potential consequence to the physician that would appear to be self-inflicted since the physician traditionally has the authority to make the final health care decisions regarding patients.

A consequence of the physician’s role being associated with masculine discourse is that a boundary is established around the physician so that other voices have difficulty participating in decision-making. A feminine discourse would not insist on a single voice of authority and certainty as the decision-maker, but would promote multiple voices participating in difficult decisions to benefit the patient. The fluidity of feminine discourse reflects both the health care environment as well as the disease process as constantly evolving and changing entities. When health care is provided in a cooperative environment, there is a greater possibility of creative decisions being made because participants are able to provide unique perspectives from their specific interactions with the patient. As reflected in the case study, health care is not a stable process, like a solid, that remains relatively unchanged, but rather flows from one situation and treatment intervention to the next. Instead of limiting the discussion of possibilities, feminine discourse would embrace the uncertain nature of the situation and use it creatively. The multiplicity of various points of view could be used to analyze difficult ethical dilemmas involving patient care.
In the case study Dr. Peel’s authority to be the primary decision-maker becomes an ethical issue with possible negative consequences. Not only does the physician make a decision without knowledge of the patient’s wishes regarding his end-of-life care, but the physician harms himself by not taking advantage of all the tools that he has available to make the most appropriate decision on behalf of the patient. By making the decision without listening to other relevant voices, the physician reinforces his isolation within the health care environment. As a result of preventing Ms. Stone from contributing to the discussion of Mr. Green’s care, other nurses may trust Dr. Peel less and not offer information to him in the future. Although Dr. Peel fulfills his interpretation of beneficence (to extend the patient’s life), his interpretation does not include what Mr. Green considers to be to his benefit. Dr. Peel makes a decision based on incomplete information so that the ethical significance of his action is diminished.

Dr. Peel, by claiming the sole obligation of beneficence toward the patient, also is limited from moving beyond the obligation of caring-for the patient to an ideal of caring-about the patient. Ms. Stone attempts to inform the physician of the patients’ preferences that she had obtained during times of intimacy in which the patient felt comfortable to express his wishes to her. By not participating in the emotional aspect of the patient’s care, Dr. Peel thus bases the treatment decisions on the minimal obligations of caring-for patients by providing medical care based on what he considers a standard to patients. By not being able to recognize how his care of Mr. Green could be enhanced by seeking the ideal of caring-about rather than just the obligation of caring-for, Dr. Peel is unable
to experience a deeper connection to the patient. If the physician allows Ms. Stone to mediate between himself and the patient to reach a deeper, emotional level of patient care, Dr. Peel could have a glimpse of the benefits that a feminine discourse could bring to relationships in health care. Without this experience of a deeper connection to patients, especially at the end of life, the physician could be limited in the ability to practice medicine to the fullest capability. Although Dr. Peel apparently does not experience the ideal of caring about his patient, many physicians participate in an emotional connection with patients and their families. As physicians experience a fluid connection with their patients rather than one based strictly on an authoritative relationship feminine discourse can be witnessed within the rigid crevices of the health care environment.

Analysis of Case Using Sexual Difference

Balancing Feminine and Masculine Discourse

In returning to this case, I will analyze how gendered discourse affected the overall decision-making process in this situation and how sensitivity to the feminine imaginary can open the process to different possibilities for other outcomes for all of the participants in this case. I will provide specific examples of how a balancing of feminine and masculine discourse would broaden the possibilities of the traditional ethical analyses.

This case study represents a fairly typical progression of patient care at the end-of-life
in a hospital setting. The decision to place the patient on the ventilator is not necessarily an unethical decision\textsuperscript{22}. If a feminine discourse had been permitted to enter the process, the decision-making process could have produced a different outcome that would have resulted in the patient's wishes being considered.

While Ms. Stone's feminine imaginary led her to attempt to add her voice to the decision-making process as an advocate for her patient, she worked within an institution that did not recognize the value of voices other than the physician's to make patient decisions. She risked crossing the boundary established by the masculine discourse in health care that only permits a singular voice of authority. One of the reasons that Ms. Stone attempted to be a mediator for her patient was that she had established an emotional connection with both Mr. Green and his family, and thus was willing to go beyond the minimal obligation of caring-for him and seek to fulfill the ideal of caring-about him.

If the conflicting interpretations of the obligation of beneficence had been recognized, a process of specification could have been used to determine which one would be ethically appropriate for this case. It would be necessary to consider as many circumstances of the case as possible so that Mr. Green's specific situation would be part of the decision-making process. The masculine discourse dictated that the physician consider the elements of the patient's physical condition as determined pertinent by the physician. There is no indication in this case that Dr. Peel made a decision based on inadequate
medical information, and therefore it was his responsibility to make the decision based on what information he deemed appropriate. If feminine discourse were to have entered this discussion, multiple voices of those who had treated the patient over time could have been solicited. This would have allowed a greater variety of circumstances to enter the decision-making process, including information regarding the patient’s preferences as well as his mental and emotional status. This would have added a dimension of multiplicity to the process of deciding about the patient’s treatment.

The possibilities of other decisions being made in this case increase when feminine discourse is considered due to its qualities of multiplicity and fluidity. There are potential problems if only a feminine discourse is used since a decision ultimately needed to be made. Limitations would be needed to contain feminine discourse from being so multiple and fluid that a final decision could not be reached. Masculine discourse can provide some structure to this uncertain and dynamic health care system. By making authoritative decisions, physicians are able to limit the influence of multiple voices with multiple interpretations, which would increase the uncertainty of a possible decision. A careful balancing of feminine and masculine discourse is necessary to ensure that more voices can enter into the decision-making process, and that a decision can finally be reached.

Since Mr. Green had been hospitalized on multiple occasions, it would not have been an efficient use of time to try to contact every person who had previously been in contact
with the patient. A process was needed to enhance the decision made on behalf of the patient. It would combine a feminine discourse in which multiple voices and interpretations of the patient’s condition and preferences could be heard with a masculine discourse represented by established guidelines to make the process efficient. Involving these multiple voices in decision-making would require thinking about possibilities outside of the traditional pattern of health care that focuses on the sole voice of the physician.

Policies

In an effort to increase the voices in the decision-making process about a patient, policies could be written to establish specific methods of communication of information so that all who have pertinent information would know the means to make it available for a decision to be made. The nonphysician caregivers would need to be assured that it was appropriate to document conversations with patients even if the information was obtained during a time of caring-about. Although nurses and physical therapists already are taught to document subjective information obtained from their patients, an environment reinforcing the appropriateness of this type of documentation would be necessary so that they would not feel threatened by those in authoritative positions. Some facilities already utilize a system whereby all health care providers write their progress notes in the same section of the chart. In this system, the documentation by various health care providers is not separated in the chart so that it can be easily overlooked. When it is written as one continuous progress report, there is a greater opportunity for all of the providers’
observations to be communicated. This type of documentation in the medical record would reflect a feminine discourse of fluidity and multiplicity. By encouraging various voices to enter into an ongoing accounting of patient care, more persons' voices can become advocates or mediators for the patient.

In situations requiring a decision to be made about a patient that would require an ethics committee consultation, policies could be established requiring notification via the medical record or institutional channels of communication (e-mail or memorandum) so that all staff members would be made aware that a decision was pending on a patient. In this case, notices could have been posted on the patient's medical record and in the nursing unit, notifying all staff who had cared-for Mr. Green to either send their comments in writing or to attend a meeting at a designated time. All health care providers would know the procedure for offering valuable information on behalf of the patient. Harm to the patient could also have been lessened if those health care providers who had established relationships with the patient based on caring-about had been allowed to convey the emotional component of that relationship to others involved in the decision-making process. The decision-making process could have included policies based on feminine discourse that would enhance the cooperation among health care providers. By focusing the decision on the patient's situation, other possibilities for the patient's care could have been considered.

Ethics committees developed so that ethical issues could be discussed by a
multidisciplinary group of persons who were sensitive to the ethical ramifications of health care. These committees are evidence of feminine discourse trying to emerge from within the masculine discourse of the health care institution. Although ethics committees grew out of a feminine discourse that promoted multiplicity, they reside within the health care institution controlled by a masculine discourse. In this case there was an ethics committee available so that ethical issues could be discussed by multiple voices. Masculine discourse played a role of limiting those voices by having a physician as the gatekeeper to the committee who had the authority to limit what cases were actually heard by the committee. In order for cases that include characteristics of feminine discourse to be heard and discussed, ethics committees would need to be arranged with less hierarchical and authoritative voices in control.

For broader types of ethical concerns to be considered by the ethics committee, and thus extending the influence of feminine discourse, new policies for handling cases would be necessary. There should be a mechanism so that several persons are involved in the choosing of cases. This is not advocating an open forum in which every case that is brought forward would be heard by the committee, for some cases do not include ethical issues and can be solved by a mediator who facilitates better communication or who provides necessary information to solve a problem. Rather, there should be less emphasis on the gatekeeper function, especially by a physician who may have a limited focus. The process of the ethics committee should foster respect and cooperation among health care providers so that patients' best interests can be served. By a careful
balancing of feminine and masculine discourse, an ethics committee can blend the multiplicity of voices with policies designed to enhance ethical decision-making.

Relevance of Sexual Difference and Gendered Discourse for Health Care Ethics

In an institution that is dominated by masculine discourse, Irigaray’s interpretations of the body and its relationship to gendered discourse may seem foreign. She uses a phenomenological interpretation of the body, while those in health care usually focus only on the biological function of the body. If her work is read as being essentialist or based on woman’s biological functions, it will not make sense to those who view the female and male bodies from their purely biological components. Irigaray’s work must be read with a sensitivity to a feminine imaginary and an awareness that women and men experience the world differently based on their sexualities. She has demonstrated through her mimetic techniques the possibility of multiple interpretations of discourse. She describes how we should be receptive to subtle signs that we may recognize in our imaginary and through the recognition of a dissonance in the historical interpretations and our own experiences. Irigaray’s work provides ways to recognize other forms of discourse that are buried under the dominant masculine discourse.

Since a feminine imaginary grows out of woman’s experiences, and a feminine discourse emphasizes context, Irigaray recognizes that this discourse cannot reside solely in the unconscious. She says:
The first issue facing liberation movements is that of making each woman 'conscious' of the fact that what she has felt in her personal experience is a condition shared by all women, thus **allowing that experience to be politicized**" (TS 164).

For the feminine imaginary to be public, it must involve establishing a feminine symbolic. Irigaray clearly intends her work to be public and political\(^{23}\), yet she does not advocate inverting the power structures. She is trying to escape the traditional order of things. One of the problems that confronts Irigaray is how to escape phallocentrism when the common discourse is dominated with the masculine view. She recognizes that there are dangers in working within the current institutional structures, yet she must work with them in order to escape masculine discourse. This is illustrated by her use of mimesis in which she uses the masculine voice to undermine the masculine discourse. She explains that trying to modify woman's status within the existing structures "may constitute a more subtly concealed exploitation of women" (TS 81). There is a risk that the current structures are so well accepted by society that if a feminine discourse is used to expose them, that it will be further marginalized and overlooked.

Sexual difference would not result in the denunciation of masculine discourse. Rather, the recognition of sexual difference should promote the emphasis on both a feminine and masculine discourse so that a discourse based on indifference that values only the
interpretation of one sex can be exposed. The recognition of sexual difference should allow the characteristics of both sexes to be celebrated for their unique qualities and how they can be used in discourse. In health care if sexual difference were recognized and both gendered discourses could be accepted as necessary components of patient care, more voices would interact to promote better cooperation among health care providers to allow better care for patients. By valuing both discourses, respect would be engendered for those working toward the benefit of patients. This would allow a greater sense of interdependence among health care providers so that the patients as well as the providers could benefit from the knowledge and expertise of all of those who participate in health care.

While Beauchamp and Childress have attempted to make principlism and casuistry more responsive to the individual patient’s situation and circumstances by using specification and balancing, the principles continue to be applied from a too narrow perspective. In order for health care principles to be appropriately used to analyze health care relationships that include both structural and dynamic elements, they will need to include qualities of multiplicity and fluidity in order to address relationships that are based on those characteristics. The inclusion of specification and balancing with an emphasis on the circumstances of the situation is an indication that feminine discourse is working beneath the surface of the traditional ethical analyses. As I have shown, even these remnants of feminine discourse can be overwhelmed by the masculine discourse seeking to limit their expression. The question remains how to promote the utilization of
feminine discourse in health care ethics.

As Irigaray's work has indicated, feminine discourse cannot be taught directly to those who are insensitive or who deny its existence because it will be ignored, trivialized or marginalized. A method of teaching gendered discourse must be developed so that it arises from within the recognizable masculine discourse but indirectly allows feminine discourse to emerge. Irigaray's technique of mimesis could be used to weave sexual difference into the teaching of principlism, casuistry, care, and other ethical methodologies to health care providers. An example of how this could be done is by using case studies and showing the multiple ways that they can be interpreted. A case would first be analyzed using the traditional methods, and then it would be reinterpreted from a perspective including sexual difference. In this way gendered discourse would emerge from within the traditional and recognizable discourse of health care. The person teaching ethics in such a manner would necessarily have to be sensitive to a feminine imaginary and have an understanding of how health care and its educational programs are grounded in masculine discourse.

Students in health care programs as well as providers are accustomed to using a discourse that limits them by focusing on the elimination of uncertainty in the quest for an answer\textsuperscript{25}. The leader of a case discussion may have to demonstrate how thinking creatively outside of the accepted masculine discourse can generate new possibilities. This person would not encourage students to "listen to their feminine imaginaries," but
rather to be aware of situations that might seem incongruous or might have gaps.

When teaching ethics with a sensitivity to sexual difference, the end-of-life case study could be presented in an abbreviated fashion that ends after Dr. Peel had written the order for Mr. Green to be transferred to the ICU and placed on a ventilator. Students would not be told that the nurse had intervened in the care of the patient. They would be asked if they sensed that there was an ethical dilemma. Some students might immediately describe a conflict between the physician’s decision and the patient’s wishes. These students would be those sensitive to the dissonance that arises from within this case. However, since health care providers are educated in the masculine discourse of laws and rules, many students might agree that Dr. Peel practiced ethically. They have learned to practice within a system in which the physician holds the superior position in the hierarchy and is recognized as having the singular voice of authority. In order for students to recognize an ethical issue, they might have to be encouraged to think from a different perspective.

Irigaray’s method of mimetic reading could be used at this point. Although the case would first be read as representative of the dominant masculine authority, students would then be encouraged to reread the case from a different perspective. Instead of just considering the physician’s role in the decision-making process, they would be asked to try to consider others who might be affected by the process, such as how the patient would feel about his treatment or how the other staff members in the hospital might
respond. This would require them to step outside the normal discourse of health care in
order to consider multiple participants in the case and to recognize the value of other
voices in this case. By encouraging the analysis of the case from several perspectives,
the students could begin to develop a sensitivity to a feminine discourse of multiplicity.

To stimulate a discussion on the value of health care providers working interdependently,
the rest of the case would be presented. A discussion could be encouraged regarding the
appropriateness of the nurse’s interaction with the physician. Those students who are
held firmly within the masculine discourse may believe that the established authority of
the physician should not be challenged. Those who are sensing that multiple viewpoints
within the health care system are valuable, might argue in favor of the nurse expressing
her concerns without fear of reprisal. By recognizing that the patient’s care would be
different if other voices entered into the decision-making process, students might be able
to recognize the importance of being aware of how other health care providers’ roles in
health care could affect their own quality of patient care. For example, if Dr. Peel had
recognized or valued Ms. Stone’s expertise as a nurse in assessing a patient’s
psychosocial situation, he could have obtained important information in a collegial
fashion so that the patient’s preferences would have been honored.

While students in health care professional programs may be taught the technical
differences in the various professions, there is little effort to teach health care
professionals to respect and value each other’s roles in health care. The educational
curricula of all of the health care professions could place a greater emphasis on
interdisciplinary coursework. By using case studies, students can try to understand what would happen to a patient without other providers being aware of their obligations to patients. If the nurse in the case had not spoken on behalf of the patient, the patient’s wishes may never have been considered. This case also illustrates the consequences to all of the participants in patient care when masculine discourse prevails and other voices are silenced. If students begin to recognize these consequences, they are beginning to hear signals from their feminine imaginary.

Students learning to use feminine discourse to address ethical issues would also need to be taught to think fluidly, rather than in the standard masculine discourse of trying to limit uncertainty by choosing what may be considered as the appropriate answer. A person teaching ethics who is interested in promoting an awareness of gendered discourse would encourage students to think creatively so that a variety of possibilities for outcomes to this case could be considered. Masculine discourse would lead students to think in terms of either admitting the patient to the ICU on a ventilator in an effort to extend his life or to stop treatment and let him die. Persons who can access the creative feminine imaginary may be able to recommend other possibilities that are less rigid and have more dynamic properties. These possibilities could include discussing with the family a preset amount of time to try the ventilator with Mr. Green, and if his condition does not improve in a certain amount of time, that he would be moved back to the nursing unit where comfort care would be emphasized. Other options might include having hospice come to the hospital, transferring Mr. Green to a hospice facility, or
allowing Mr. Green to be discharged so that he could receive care at home. All of these options, and there are others such as euthanasia that could be discussed, would emphasize not only honoring Mr. Green’s wishes, but also an aspect of caring—about the patient and family as they face the end of his life together.

This case could also be discussed from the perspective of how health care providers can serve as intermediaries between patients and the larger health care system. Not only does this case illustrate how Ms. Stone attempted to mediate between the patient and the physician, but more importantly the need for an intermediary between the patient and the institution. Health care providers need to be aware of the masculine discourse that dominates the institution itself. The hierarchical nature of the system, the rigidity of rules, and practice based on standards of care tend to diminish the importance of the individuality of the patient. This case illustrates how Mr. Green expected his preferences to be carried out, but how his wishes became lost in a system that emphasizes "providing the best medical care possible." While the importance of medical standards in health care should not be overlooked, it should be mediated by the specificity of patients’ circumstances and preferences. Unless health care providers are sensitized to the possible consequences when these two aspects are not woven together, they unfortunately will resort to a masculine discourse that emphasizes sameness rather than difference.

When health care decisions are being made about patients, the voices of all who have information regarding the patient’s physical, emotional, and psychological state should
participate in the discussions. In this way, when patients cannot speak for themselves, their desires may more accurately be addressed. As decisions are being made about patients, multiple voices should be sought, but a final decision still must be made. In addition to a feminine discourse of multiplicity and fluidity, there also need to be some guidelines that would limit an infinite search for those with information. Instead of merely open-ended discussions that may not serve the purposes of the patient, decision-making should be guided by policies that are developed with respect for all involved.

As in the interpretation of principles, there is a role for masculine discourse in the application of principles in specific situations. While it is important to include flexibility and fluidity in the utilization of principles because they are being used in an environment of change, ambiguity, and uncertainty, there also is a place for cautiously delineated boundaries. These boundaries while derived from a masculine discourse would also need to be mediated by a feminine quality so that these boundaries would be permeable. Because the institution of health care and the relationships within it fluctuate so extensively, rigid and fixed boundaries would not promote an environment of cooperation. However, it would also be unproductive if principles were applied in such a diffuse manner that they could never be useful. A careful balancing within relationships is necessary, so that a fluid exchange of information is combined with boundaries to help direct the process. While it is necessary to include multiple points of view and varying interpretations in decision-making, a publicly acceptable standard of practice is also necessary.
Although the use of gendered discourse in health care may be difficult to teach, feminine discourse can successfully broaden the possibilities for patient care. The development of ethics committees has helped improve the decision-making process for patient care by emphasizing the importance of the multiplicity of voices and the interdependent nature of health care interprofessional relationships. Even though ethics committees continue to function within a broader institutional setting dominated by masculine discourse, they have helped to promote more voices with multiple viewpoints to participate in a more creative health care decision-making process. Other instances of feminine discourse emerging into health care can be seen in the care of patients at the end of their lives. Evidence of a feminine discourse of multiplicity can be found in cases where other choices are offered to patients other than full life-sustaining treatments or immediate death. Where choices such as hospice or home comfort care have been found acceptable in the health care community, these more creative possibilities have been successful in helping patients and their families feel cared-about in a system that traditionally has only cared-for them.

By weaving feminine and masculine discourses together into principlism, casuistry, and care, patient care decisions can be made with a different level of analysis. Rather than searching for an answer from within the masculine discourse of authority and sameness, decisions can be made with a greater degree of sensitivity to the different possibilities that exist when all of the providers of health care work together for the benefit of the patient. The traditional ethical methodologies of principlism, casuistry, and care have
proven useful in analyzing difficult health care dilemmas. With a sensitivity to the relevance of gendered discourse to health care and its ethical analyses, these methods can continue to provide an even greater depth of analysis to dilemmas in health care, especially when they involve issues that are derived from interprofessional relationships. By recognizing and utilizing our imaginations, new and creative possibilities may become apparent so that our caregiving efforts can be optimized. We can use Luce Irigaray’s work, not as a guide to find solutions to difficult problems in health care, but to help raise an awareness and sensitivity to the opportunities that exist. Her work promotes looking beyond what we have too narrowly defined, to find other possibilities. She says: "Our horizon will never stop expanding; we are always open" (TS 213). As health care ethics continues to evolve, it has the opportunity to incorporate discourses that may sound different but reflect the dynamic qualities of the health care system and its providers.

NOTES

Chapter Five

1. Later I will explain how an ethic of care can be derived from feminist writings, yet is grounded in masculine discourse.

2. This case is a composite of situations that I have observed in health care practice. The names are fictitious.

3. The lack of documentation regarding Mr. Green’s preferences will be addressed throughout this chapter.

4. Although masculine discourse in health care can be associated with those in authoritative positions, the emphasis of this work is not on the power or authority of those persons, but rather on recognizing how gendered discourse as phenomenologically described by Irigaray affects both the providers and consumers of health care. I will associate the female voice in health care with that of the nonphysician health care
provider, specifically nurses and physical therapists, since those professions are overwhelmingly dominated by females as opposed to the male voice of the physician. Throughout this chapter I will describe how these gender designations can be interpreted to reflect the discourse used by each of these professions and how they function within the health care system. Although I acknowledge that these professions and gender designations cannot be strictly applied because all nurses and physical therapists are not female and all physicians are not male, I will not attempt to specify this caveat every time I mention the differences in feminine and masculine discourse as designated by profession. It is clear that since there are male nonphysician providers and female physicians, that it is impossible to try to categorize the professions based on the gender of their constituents. My comments regarding gender are based on an Irigarayan interpretation of the functions and discourse associated with these groups. I will explain the necessity for a gendered discourse to have the capability of being used and understood by both genders without being based on their biological differences.

5. An obvious example of this phenomenon is the nurse's being reassigned in the case. Another example of feminine discourse being dismissed is the lack of recognition of a different discourse found in nursing literature.

6. In Medicine and the reign of technology (Cambridge: Cambridge University Press, 1978), Stanley Joel Reiser describes the historical development of physician diagnosis. He explains that in the seventeenth century, the physician used "verbal and visual techniques to make a diagnosis" and in the eighteenth century manual techniques were initiated (22). With the advent of technology in the nineteenth century, Reiser explains that the physician used the visual sense to investigate internal disease by use of instrumentation. This fits with Irigaray's discussion of the use of the speculum to inspect woman. Reiser describes how certain technological advances, such as the microscope and X-rays, "encouraged a physical separation of the doctor from his patient in the diagnosis of illness" (90). While some physicians thought that the use of technology would allow them more direct time with patients, Reiser explains that this has not been the actual result.

7. While sight and touch are the only senses that I have been addressing in this case in an effort to focus on a limited set of variables, other senses could also be involved. The physical therapist has heard the screams of the patient during the attempts at treatment. Hearing could also be used to overcome the separation of the positions of the providers. They would need to be open to listening not only to the patient but to each other and how each one interacts with the patient. The sense of smell also is used to make health care decisions.

8. In The Healer's Art: A New Approach to the Doctor-Patient Relationship (Philadelphia: J.B. Lippincott Company, 1976), Eric J. Cassell discusses how some physicians have difficulty understanding how to incorporate subjective information with objective data into patient care (96). He explains that physicians are trained in "analytical thinking" that may "lead away from considerations of the whole person" (99).
Although I have not specifically addressed the categories of objectivity and subjectivity as being related to gendered discourse, I believe that there is a connection between masculine discourse emphasizing the observable and more measurable aspects of objectivity and feminine discourse being related to subjective information that is obtained in a more fluid environment.

9. I will discuss the interpretation of obligations and principlism using gendered discourse in the following section.

10. Although health care providers also have obligations to patients to uphold other health care principles, such as nonmaleficence and justice. I am limiting the discussion here to beneficence and autonomy. Because I am not trying to critique the principles per se, but rather the limitations regarding their use, I am using primarily beneficence and to a lesser extent autonomy in this discussion as examples of how gendered discourse affects the use of principles. By restricting my comments to these two principles, I am not trying to give priority to these principles.

11. The term "allied" health care provider designates these professionals as contingent upon physicians. Because it maintains their position as marginal in the provision of health care, many physical therapists, nurses, occupational therapists, and other nonphysician health care providers find the term objectionable.

12. Although it may be an area for future study, I am not attempting to establish a relationship between writing and orality with masculine and feminine discourse. However, in this case, the physician may have associated what was written in the chart, which is a legal document, with more objective information that would be associated with masculine discourse.

13. In an earlier chapter I discussed how the institution of medicine historically and traditionally developed as the health care profession with the greatest authority. I discussed how the authority of physicians and their resultant place in the superior position of the health care hierarchy are associated with gender. Irigaray’s phenomenological explanation of masculine discourse can then be applied to physicians who invoke their positions of authority in health care decision-making.

14. It should be noted that if Ms. Stone had written Mr. Green’s preferences in the chart, she may have had less of a conflict with the institutional factors.

15. As Noddings describes natural caring, it could also be detrimental to men, especially those who have primary child-rearing responsibilities.

16. Although I have addressed essentialism in earlier chapters, Noddings’ use of it needs to be recognized. When an emphasis is placed on woman’s role in procreation, sometimes a result is that women are restricted from certain activities which places them in a vulnerable position.
17. In *Medicine and the reign of technology* (Cambridge: Cambridge University Press, 1978), Stanley Joel Reiser describes the diagnostic role of the physician as having historically evolved from aural and visual to one of manual technique and finally returning to the visual with the advent of technology. He explains that in 1900 nearly 60% of medical personnel were physicians, but in 1971 physicians comprised only 20% of the health care work force. He describes how physicians began delegating responsibilities to nonphysician health care providers who were "supervised" by physicians (221).

Irigaray's work is pertinent to health care ethical concerns because the institution of health care reflects the values of society at large. Irigaray's work has been used to uncover the extent of masculine discourse in society at large and her methods can also reveal how health care is permeated with gendered discourse. Although ethical concerns that may have gender components, such as discrimination in admission policies to medical schools, are currently being corrected, structural elements such as authority, which were historically established along gender lines, continue to exist. In society and health care, males have traditionally held the positions of authority to make decisions while women have been valued for their work that historically has been associated with the private realm of the home. Women in the health care professions are often not only powerless, but also made to be invisible and discounted in their roles as health care providers, especially when associated with their maternal roles.

Since nonphysician health care providers who provide the majority of hands-on care of patients have little authority that is often reflected in their lower incomes than either physicians or persons in administrative positions, it appears that directly providing hands-on care for patients is valued less by the institution of health care. Therefore, in order to advance in the health care environment, nonphysician caregivers usually must leave direct patient care to assume administrative positions. Administrative positions are a part of the hierarchical arrangement that are more valued in a masculine discourse. Because of the hierarchical system in health care, women in health care continue to face obstacles if they want to continue direct patient care. Once again it can be seen in health care that the roles of women that are associated with nurturing and caring, continue to be devalued. This devaluation plays an important part in how health care providers relate to each other.

18. I will return to the importance of communicating information obtained from caring-for and caring-about a patient in the medical record when I discuss how policies can promote the inclusion of feminine and masculine discourse in decision-making.

19. I am not addressing whether a physician is discouraging, not supporting, or keeping one from fulfilling an obligation. It is the discourse, not the physician's actions, that are relevant. Therefore, I am not addressing whether a physician hinders the nurse somewhat from fulfilling her obligation to the patient. Since the nurse expressed her concerns about the patient's care and voiced the patient's wishes, she is fulfilling her
obligation to the extent that the system allows her.

20. I use discourses in the plural because I do not want to prohibit the possibility of there being other discourses besides those based on masculine and feminine gender.

21. There are several other possibilities why the other staff members did not speak up. They could have feared the possible reprisals that exist when the authority of others in the hierarchy is challenged. They may also have agreed with the physician.

22. It could be argued that since the physician did not follow the patient’s preferences, that this case is primarily a conflict between the physician’s principle of beneficence and the patient’s autonomy, and that the physician violated the patient’s right to autonomy. However, there is no evidence that the patient ever voiced his wishes to the physician, and since the family asked the physician to make the decision, there would not be a conflict. In fact, unless the nurse had spoken about her concerns, no ethical dilemma would have been identified in this case. Therefore, I am focusing the ethical concerns of this case on why the nurse’s concerns were not considered in the determination of how this patient would be treated at the end-of-life.

Gendered discourse may also play a role in the patient/provider relationship and could provide a possible explanation for why the patient did not voice his preferences to the physician. It is possible that when Dr. Peel spoke with Mr. Green in a manner that did not invite a fluid exchange of information, Mr. Green may have sensed that Dr. Peel did not care-about knowing his wishes, but rather was only interested in telling his patient how he could care-for him. Without the emotional connection, Mr. Green may not have felt that he could speak freely with Dr. Peel. Further, since Dr. Peel interpreted his obligation of beneficence as prolonging Mr. Green’s life, Mr. Green may not have wanted to disagree directly with him since many patients find it difficult to disagree with their physicians. There are other possibilities why Mr. Green did not speak to Dr. Peel about his preferences. Dr. Peel may not have given him the opportunity to discuss his wishes, or Mr. Green may not have physically or emotionally felt like discussing his preferences when Dr. Peel made rounds. The case does not provide the information necessary to try to determine Mr. Green’s motivations. While this relationship is critical in health care, the focus of this work is on the relationships among health care providers and the resulting effect on patient care. Further investigation of the patient’s reluctance to reveal his preferences to the physician is necessary.

23. Irigaray claims that her work is clearly political if the definition of the political is expanded from its strictly masculine confines. In "Essentially Speaking': Luce Irigaray’s Language of Essence" in Revaluing French Feminism: Critical Essays on Difference, Agency, and Culture eds. Nancy Fraser and Sandra Lee Bartky (Bloomington: Indiana University Press, 1992), Diana J. Fuss explains that for Irigaray, "a ‘feminine politics’...is inseparable from the project of putting the feminine into history, into discourse, and into culture" (106).
24. The health care professions are becoming less distinctly separated by the structural elements of health care relationships which have been described as authority, education, socio-economic levels, and gender. Nurses now are often in institutional positions of decision-making and in managed care settings, they now often act as gatekeepers or as the point of patient contact in physician's offices. The lines of authority are not as evident as they once were as nurses and physical therapists seek and gain legislative means to the legal right of treating patients with less physician involvement. I have also discussed how the educational backgrounds of many health care providers are expanding in depth and in breadth, while at the same time, specialization continues to expand, thus resulting in less of a rigid dividing line between those who should have a voice in the decision-making for a patient. For example, in the care of a patient with cancer, an oncology nurse may have a better understanding of the patient's situation than a physician without special training in the care of cancer patients. While physicians continue to enjoy a higher socio-economic level, many physical therapists are finding practice outside of the hospital setting more lucrative, and this structural element may be becoming less distinct. Managed care may also result in structural elements becoming less divisive among health care providers so that more persons from various backgrounds will be able to participate in health care decision-making. Although the element of gender is also gradually becoming less distinct as more women graduate from medical schools, gender may continue to be a divisive factor until feminine discourse becomes more recognized as a factor in ethical analysis in health care. As the feminine imaginary is accessed and recognized by those who are members of the health care environment, the dominance of masculine discourse, as previously maintained by way of structural elements of relationships, can be lessened to allow for more voices and more varied interpretations of principles and cases to be heard and acknowledged as necessary components of patient care.

While the structural elements of health care relationships are becoming less rigid and less reflective of masculine discourse as discussed above, the dynamic elements of relationships already include characteristics of feminine discourse. These elements which I previously identified are the multiple levels and roles of practitioners, the level of intimacy developed, and the public/private continuum. Further, the level of intimacy between patient and provider and among providers is so variable that relationships may constantly move along the intimate/stranger continuum. This dynamic element reflects the fluid nature of relationships. Similarly, the fact that health care is of a private nature but is provided within a public environment, means that it cannot be considered one or the other, but rather moves fluidly along that continuum. Therefore, each of these dynamic elements of health care relationships can be recognized as having some of the characteristics of feminine discourse. When principles are being applied to the ethical dilemmas which arise from within these relationships, then they should be able to address the fluidity and multiplicity of these relationships.

medical student "be taught to honor subjective information from patients as he presently honors objective data" (120). If more attention were paid to the patient’s voice, as often communicated via nurses or other nonphysician health care providers, decisions could be made more appropriately based on the patient’s specific situation and wishes.
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