

Chapter 9

Care: A Critique of the Ethics and Emotion of Care

Abstract This chapter aims at the clarification of the notion of care on the basis of the cognitive-emotive theory of caring. Care theories are presented and critiqued. Bonding is analyzed. Empathy, sympathy and helper's syndrome are examined. A philosophy of caring is presented rather than only morals of caring. An analysis of caring is seen to require an analysis of ethics, the self, causes of action, motivation, and emotion. It is also shown how caring may be redefined and based on a naturalistic, humanistic theory of ethics. Philosophy and ethics of personality involve the emotion of care towards the humanistic concept of rational care.

Keywords Care · caring · care theories · bonding · care as emotion · rational caring · The Patient's Hippocratic Oath · empathy · humanism · Philosophy and Ethics of Personality

9.1 Introduction

This chapter aims at a clarification of the notion of care and care theory that has been discussed recently in the area of bioethics and the philosophy of medicine. This means that it is a criticism of the language and methods involved in care.

Even if we theoretically know we should help others who are in desperate need, why do we not actually do it? We often basically care only when it is our professional duty to do so and delegate care to those on duty alone even when we could share care. We may do things to or at people rather than for or with them. If we regard the other as part of oneself (identification) it can be just a form of egoistic caring or self-caring. We can identify with a patient or physician. We may also care because by so doing we have a good view of ourselves which generates a positive emotion. By contrast, a rational naturalistic humanist is universally caring – not because of ego or direct self-gain, but because it makes sense to do so in terms of consequences just as it makes sense to be a critical world citizen. Civil or social caring is concerned with others in society both local and international. The world is my family. Universal caring could put care for the individual in the context and perspective of caring on a larger scale. We may compare the Greens' slogan: Think globally, act locally. The naturalistic ethical theory does not support

selfishness because humanistic ethics is based on inquiry and consequences leading to the understanding that one wants to live harmoniously and ecologically in the world and society at large. Bringing about one's own wants as well is not selfishness. Selfishness rather is defined as doing good for oneself while not caring about or doing bad for another. However, by definition, bad is nothing one would want to do. Naturalistic ethics, more than any other ethics, has led to humanism and altruism, both of which may be recommended as goals in the helping professions. Basically, the view of John Dewey, humanists and pragmatists is that ethics is consequentialistic involving enhancing human wants and abilities to the maximum in harmony with others and with nature now and in the future. The basis of naturalistic ethics is the bringing about of one's likes, wants, enjoyments and desires. Caring would have the same basis.

The question of what causes us to act in general is raised. The caring aspect with stress on individual wants and needs is especially contained in a naturalistic ethics. Thus, care may be regarded as balanced, humanistic treatment thereby producing care. Thus it cannot be negative or interfering. In caring, on this view, one should not be controlling, but humanistic, one should not be dogmatic, but open to specific needs. There might be problems of balancing of caring for one person against all others, and of having only inadequate resources to provide proper care. There might be unenlightened management, which prevents adequate caring, etc. It was found that one-third of 40 doctors showed "almost total lack of awareness how to interact in a professional manner" [1].

In the following, the theories and views, which will be presented, are contrasted with such a humanistic, naturalistic ethics.

9.2 Care Theories

The ethics of care for Noddings view is basically a deduction from anti-patriarchal feminist philosophy [2].

Accordingly, Noddings states that caring is feminine, cared-for is masculine. Caring comes from women [3]. "Logos, is the masculine spirit, whereas the more natural and, perhaps, stronger approach would be through Eros, the feminine spirit." This view commits the fallacy that emotions (female) are different from cognitions (male), whereas emotions involve cognitions. Her view also falsely regards emotion as a female quality, and reason as a male quality. Women and men both have emotions and reason. "Ethics has been discussed largely in the language of the father: in principles. . .the mother's voice has been silent" [4]. She thinks caring is based on the maternal instinct, is "maternal caring," caring as mothering, a certain kind of bodily feeling without language. This would exclude males and male language. Thus it sounds contradictory when Groenhout states that we should all engage in good mothering practices [5]. The move for Noddings is to only allow feminine knowledge and emotions, which only females can have. Caring comes from women. Her view, then, is that of gender caring, specifically, matriarchal caring instead of patriarchal caring. Groenhout, however, critiques Noddings view about mothering and suggests that there can be better and worse mothering, and that mothering can often

be oppressive exploitation [6]. On her view, care theory is built from the “familial relationship,” not just any mothering.

Noddings states, “Women have actually done most of the care-giving work for centuries” [7]. This is a questionable statement because men have been and still are the primary family providers. However, Noddings has recently reversed her thinking that women are more caring: “I have no idea whether women are, by nature, more caring than men. I doubt it” [8]. How unclear this theory remains is indicated by the title: “The Chaos of Care and Care Theory”, which was the topic of the 23rd issue of the *Journal of Medicine and Philosophy* [9].

In regard to Noddings anti-patriarchal feminist view Jecker and Reich state, “The close association of care with gender and the feminine voice may hinder efforts to develop a broader understanding of care” [10]. Perhaps there are gender or role differences in regard to the kind of care provided.

Caring is also further restricted. We need care only for the immediate circle, family and close friends. It is not general or universal caring, but limited caring. The question also arises as to what extent, if any, it is available to men. Noddings is opposed to universals, but the one exception is for the bodily feeling of caring [11].

To care for friends or for one’s family only is inconsistent with care for all other desperate people in the world. Ethics is not limited to one’s own patients, friends and exclusive cliques. Our actions and policies affect people we do not know. We may tend to withhold caring from those we do not know. This is the old morals of helping no one except some family members and friends who help you. It is egoism because the self is just extended to the people one identifies with. Perhaps for these reasons Noddings in her most recent work has extended her notion of caring for someone to “caring about” people in general, e.g., the starving in the world [11].

Noddings caring is connected to the mother’s (or father’s) bonding of which there are various types. Bonding is made to seem a mystical physical connection. It has a physical basis as everything else we experience and do. But such a reduction is not a good model for rational caring.

Bonding and care are confused. Is the capacity for care based on bonding experience, on mother-child-bonding and the development of bonding-styles? Bonding-theories have an influence on the psychological interpretation of the physical process of bonding, the answers of the bonding experience allowing or avoiding mother [12].

D. Eyer’s PhD dissertation on bonding is on the surface interesting, but could have benefited by adding the depth contained in philosophical analysis, philosophical psychology and the philosophy of science. Only a few philosophy texts were briefly touched on. However, her questioning of medical research on bonding was interesting [13].

Part of the evidence was from observations of animal behavior, e.g. female goats separated from their infants for a few minutes will supposedly reject them. The gosling after the third day “learns” to follow anything it takes to be its “mother,” even if it is a sailboat. To think the newborn knows it has a mother is, in any case, a personification. The infant does not “know.” Bonding is confused also because it is one thing for the mother to “bond” to the child and another for the infant to “bond” to the mother. It is a big jump from saying the teen is difficult to manage or there is poor child development because the child was not held as an infant. Parenting

requires much more than mere touching at a “magical” or alleged “sensitive” period of life. These are called confounding variables and were failed to be considered as such in the research designs [14].

In her book, *Mother-infant bonding: a scientific fiction*, Eyer fails to deal with emotion or to present a theory of emotions regarding caring. The study gives no analysis of the reasons why women behave as they do toward their offspring. Bonding was never clearly defined and varied with each study [15].

On the other hand, it makes good common sense to take gentle, protective and constant care of the infant regardless of the research or alleged consequences [16]. Reason here again can trump mechanical research. But as Eyer points out bonding should not be based on a mythical unscientific and fixed doctrinaire principle. As a result of the bonding research we have no knowledge about what it means for the mother to love or not love her child. We are given no knowledge about what love or any other bonding underlying emotion is at all. “I would like to urge the impossible – that we discard the word [bonding] entirely. Doing so would force us to recognize that strong relationships require many ingredients. . . love, understanding, trust, money, sharing, giving, stimulating, and inspiring” [17]. Bonding is a form of simplistic reductionism [18]. We cannot get around that entirely by a mere mechanical touching as bonding which is, of course the initial incentive, a neural paradigm induction. Bonding is a form of the physical medical model, as we know that emotion is embodied, as well as reason. But this all does not let us escape the question of rational bonding. What makes bonding successful in terms of consequences, in terms of the development of bonding structures which allow for autonomous development as well as for safely being bound to other people.

Tronto’s view of caring is closer to a naturalistic, humanistic theory: we should do all we can to make this a better world. Unlike Noddings view that caring only applies to one’s immediate circle, Tronto’s care is a practice in the overall social context, something one needs to do for a social context to be a social context [19]. Noddings stresses caring as a relationship, what Veatch criticizes as being unintelligibly vague [20]. Caring as “relationship” is an abstract term without analysis and not specific enough to generate a theory as caring theorists require. There is no “relationship ethics” because ethics includes relationship already. Sociability is almost a synonym of caring. To care is to be sociable. To be in a relationship requires one to participate in it. To love or care is created by one’s conscious deliberate cognition to do so if it is to be a social context. There is no relationship if one does not relate, no communication if one does not communicate.

Noddings is anti-principles, anti-rules, anti-obedience, anti-dogma, anti-reason, anti-empirical, anti-universals, anti-natural rights, anti-definitions, anti-detachment, anti-negative emotion, anti-consequential, anti-systematic [believes it is a mistake to be systematic], anti-rational (not empirical or logical or with proofs or knowledge, but rather on bodily feelings) [21]. “Aesthetic care” is care about things, ideas or money [22]. She also states that her care theory is not consequentialistic [23]. Because she is anti-principles, anti-obedience, and anti-dogma we can predict that she is anti-religion as well. She accordingly states that religion is too authoritarian,

and based on obedience, accusation, and fear to be caring. Tronto also sees caring as a non-indoctrinaire responsiveness therefore it is not religious, cultural, or indoctrinative caring [24]. Accordingly, one might suggest “humanistic care”.

Barnes defines caring in practice as good communication, understanding the patient, as action, and in terms of a therapeutic relationship (trust, respect, honesty, frankness, empathy), a most beneficial outcome. He criticizes the feminist account of Noddings [2–4], [25], and [26], who put caring on a maternal relationship only because this may lead to burn-out, favoritism, lack of objectivity, empty or vague emotional involvement at the expense of effective cure or treatment [27].

According to Tronto care is an emotion and therefore one must first understand how emotions work to then be able to discuss care. Noddings does not say how one can become caring [28]. *See in this book the Chapter 7.*

Groenhout [5] and Noddings hold that Care Theory is a genuine ethical theory. Veatch, however, gives significant criticism of care as a theory. He asks if it is a virtue theory or a theory of right action? [20] The argumentation here is that care theory is not an ethical theory at all. Care is an emotion. Groenhout’s final statement that caring needs standards of good and bad shows that caring is not an ethics, but rather requires one [29]. “Care Theory must be grounded in a substantive theory of the good” [30].

The distinction made in the earlier chapters of this book between morals as only the normative, uncritical beliefs and practices of the culture, and ethics as the critique of morals, applies here. Enlightened caring cannot be based on morals, but only on critical ethics. One can then speak of mere “moral caring” as opposed to philosophically enlightened “ethical caring.” This also implies that caretakers should be as caring to each other as to the patient.

Caring must be reciprocal. “A relation cannot properly be labeled caring in their [reciprocal or mutual responses] absence” [31] (See critique of mutuality later). Noddings recent formulation of caring shows the absolute necessity of reciprocity: “(A, B) is a caring relation. . .if and only if i. A cares for B – that is, A’s consciousness is characterized by attention and motivational displacement – and ii. A performs some act in accordance with i), and iii. B recognizes that A cares for B” [32]. If this were required it would possibly eliminate caring in most healthcare situations. This would also be true of many or most parent child caring relationships. Healthcare workers may often be defined as people who help other people who do not help them in return. Where do they then fill their resources again? This is one of care-taker burn-out reasons.

There is supposedly intrinsic giving or caring for its own sake. But this contradicts her view that we care for others because we want to be cared for ourselves [33]. Furthermore, if caring is based on mothering of a child we possibly identify ourselves with caring is based then on egoism. Can one be caring to oneself? A mother may care for a child because she wanted a child, and identifies with a child as her’s, as part of herself. Women may also have children for security, self-esteem, avoidance of work outside the house, for some imagined “fulfillment” of themselves, entertainment (“Children are so cute.”), etc. Then in effect she cares for

herself. Groenhout speaks of “identity egoism.” These commitments “constitute a part of my identity” [34].

Care is seen as being non-rational [35]. Care is supposedly a pre-act feeling or attitude. Noddings uses the term “engrossment” to describe caring [36]. It means to wholly occupy or take one’s entire attention for the other not the self. This is by definition an excess and so not a rational policy. It is like the term “enmeshment”, which is also negative involvement and dysfunction. In caring one is “engrossed,” “feeling with.” “Mothers quite naturally feel with their infants” [37]. Noddings seems to think we can feel without language. Language is regarded as a male, patriarchal institution and so to be demoted. If to be ethical requires one to be deliberate, then Noddings’ care theory is non-ethical. Caring may be unintended, habitual, automatic, or for no reasons. One may not know why one is caring. Her theory comes close to that view. Caring is a mystical, spontaneous “natural” inclination or activity [38]. From this supposedly arises an “ethical theory,” though she opposes theory.

Noddings views would seem to support the case method in bioethics. However, as it is anti-reason and anti-empirical, it would also be anti-clinical. Casuists are often relativistic, but naturalistic humanists base their views on adequate reason involving concrete situations, which would be a better basis for a case method. On Nodding’s view, we should consider only the others’ wants we should act for persons, not for principles.[36] We would be concerned for the other, not oneself. This is the traditional definition of altruism so the critical literature on altruism should be brought in. Rational caring is where one also considers oneself as Tronto also believes [39]. Care only for the patient with no consideration for the physician or nurse generates burnout. It also generates irresponsibility in the patient or other.

9.3 The Word-Field Meanings of Caring

9.3.1 Introduction

According to the American Medical Association Principles of Medical Ethics [38], a physician shall be dedicated to providing competent medical care, with compassion [40]. But what is “compassion” and what is “care”? Caring is an abstract term. Care is basically an empty, open-context, value term. Context is needed to determine its meaning. Care may mean just “good” treatment where “good” is open-context also. What one thinks is care another may think is harm or a smothering relationship. How does one care? Could one follow a rule to do so? To answer this question an interpretation of caring is needed.

There are as many uses or meanings of caring as indicated by a world-field analysis of the term, language-game, or family of related terms and synonyms. Thus, equivocation arises when caring is used in the different senses. For example, that one is caring professionally does not mean that one is caring personally, or that one is caring in the sense of being understanding or unselfish. The pragmatics of the language-games of caring shows that caring has numerous different uses in language. The word “caring” may involve a claim, an exaggeration, a description, a lie,

a joke, a way to keep the conversation going, a rationalization, an excuse, an apology, a question, an exclamation, etc. Each kind of caring may also be qualified, e.g., medical caring, therapeutic caring, holistic caring, ethical caring, humanistic caring. Caring may also be used metaphorically and applied to the entire environment. It is the extension of human caring to the harmony of all of nature in which humans live. Personified caring is to ascribe caring to animals, medical institutions (with a motto of “We care”), of governments, etc. There is also a complex pragmatics of language. Care may be an emotive expression. “He really cares!” can mean “Wow!” or “Amazing!” or “I adore him!” Care may also be used as a performative utterance: “To say one is caring is to be caring.” We may compare, “To say, ‘I love you’ is to love.” The saying is the doing.

Each meaning may be combined with other meanings to yield what caring means in any particular situation. Caring is not pure. There is always a mix of different types of caring with other cognitions and emotions. Also, at least the minimum claim may be made here that “caring” is a vague abstraction with many meanings and many fallacious uses.

One may be caring about a belief or an idea, e.g., one’s discipline, for example, medicine. One may have a passion for critical thinking (speaking) as well as humanism. Caring can apply to any subject or activity, e.g., one may take care of the medicine, children, books, hospital finances, etc. Caring in medicine done for money is not personal caring, although it can involve other types of caring. There are also as many types of carelessness as there are types or meanings of care. One can be caring in one sense, but careless in another, e.g., if one is too caring one may tend to be careless. Also, “healthcare” has several meanings. Is the care just professional healthcare or is the healthcare caring? Healthcare can have as many meanings as care has.

One method of investigation is to analyze through concept. Any word can be elevated to a theory. Thus, we may gain insight by investigations through the concept of care. “Situational ethics,” or “love theory” was also thought to be a new ethical theory by Joseph Fletcher [41]. One could speak of “x theory” where x is any ethical, emotion or cognitive word, e.g., client theory, patient theory, clinical theory, dependency theory, etc. That is, there is a philosophy in every word, which may be expanded.

Caring in healthcare may be given insight by comparing it to a love relationship. If so we would not wish a caring partner to be just an economic relationship as it is in some healthcare contexts, or to be treated merely as an independent, partial relationship relating only to the body. We would often wish a full, holistic, passionate love relationship within the bounds of appropriateness and discretion.

9.3.2 The Synonyms and Word-Field of the Term “Caring.”

Caring may be good or bad, positive or negative.

Positive meanings of “caring” are: accepting, accommodating, affectionate, altruistic, attentive, benevolent, careful, charitable, circumspect, concerned

(emotionally and cognitively), considerate, cooperative, courteous, dutiful, enthusiastic, erotic, farsighted, friendly, giving, forgiving, generous, gentle, helpful (stresses autonomy), humane, kind, indulgent, intimate, involved, judicious, loving, patient (compare with the word the “patient”), personal, prudent, reciprocal, respectful, responsible (for oneself or another), sensitive, understanding, unselfish.

Negative meanings of “caring” are: controlling, enduring, indoctrinative, intrusive, long-suffering, mothering, over-protective (unnecessary suffocating, or smothering caring), over-sympathetic, paternalistic, perfunctory (caring only out of duty), pitying, selfish, egoistic, self praising (“I am caring.”), supernaturally caring (agape), worrying. Care as worry/anxiety (*Besorgnis*) is dysfunctional caring. Any negative emotion such as sorrow, worry, pity are dysfunctional forms of caring.

9.4 Irrational Forms of Caring

(See Also Empathy and Sympathy)

Defense mechanisms. Caring may be used as a defense mechanism, e.g., a rationalization. One may claim to care as an excuse, lie, apology, etc. One may verbally claim to care, but not actually do so. One may give the appearance of caring to cover one’s genuine attitude. Care may be a fixation, transference (e.g., if one transfers one’s love of another person to the one cared for), symbolization, introjection (internalize the fears or grief of the cared-for), identification of the caretaker for the cared-for, projection (e.g., attribute one’s own illness to others), conversion (physical manifestation of a psychological problem, e.g., over-nervousness, stress), denial (e.g., false assumption that the cared-for can care for themselves), repression, intellectualization, acting-out, regression, sublimation, compensation. One may help others to compensate for one’s own guilt. One may care for someone in order that one might oneself be taken care of. This is caring as projection of one’s own desires. Dewey and Tufts state that it is possible that by false sympathy and compassion one “is weakening the character of others, and, while helping them superficially, is harming them fundamentally” [42].

Dependency-producing care. This involves making another obligated. Calculated care may be given so as to control another by making them dependent. This often occurs with mothers who thereby prevent children from becoming independent or self-capable. This may also occur, for example, with healthcare workers who do not allow their interns to gain the experience needed to be on their own. In the medical profession, the patient sometimes is made over-dependent on the physician or health care system. Care can promote dependency, overprotection, and imprisonment. The caregiver thus becomes controlling or domineering.

Detachment. Taking care of someone may mean to look after someone, but for this no emotional attachment is needed. There can be caring with a psychological distancing. It allows one to observe the most tragic situations in an accepting way so as to appreciate it in whatever ways we can. Constant negativity and tragedy are unhealthful. Humor and psychical distance have significant places in caring.

Identity egoism. Identity egoism is care as self-identification with another, a group, a clique, or with a nation or belief system. It is a form of egoism, e.g., to identify with a race, a country (nationalism), or one's family, without care or concern for others. Other is already defined in terms of the self – as other than self. When one thinks of a person as other, it almost precludes the obligation to care. One may not even care for oneself. The identification egoism of the mother with the child was critiqued in the section on Noddings' care theory.

Insufficient or excessive amount of caring. One can care too much or too little. The adequate amount of caring must be specified. It is often stated that one, in general, need not legally help others in distress, but may consider helping others if it is convenient. On the other hand, one may give as much money, time, effort as reasonably possible even at great expense to oneself. From this perspective, anyone who buys luxury goods may be seen to be letting people die. In terms of sufficiency, care must often be constant, consistent and dependable. Also, we may care in one sense of care, but not in ten other senses of care. We do not or cannot care in every sense of caring. One may, for example, care emotionally, but not cognitively or efficiently, show concern, but not do what is necessary for the patient. Hopefully, one would care in as many of the positive senses as contextually possible.

Intrinsic caring. Some hold that caring is intrinsically good or good-in-itself. Metz, for example, wrote, "It is intrinsically *valuable* to *help* others" [43]. This is a fallacious use of ethical terms because good-in-itself is unintelligible. "Intrinsic" commits the fallacy of absoluteness and the statement is also circular.

Irrationality of perfection in care: There are mistakes made by physicians and patients. One of the leading causes of death and negative outcomes of treatment is mistakes. One must accept that if one works, one will make mistakes. Physicians, like others, are not all-knowing. For financial reasons there exists lack of medical funding to increase medical knowledge, and there is strong religious opposition to needed research. People in societies usually contribute to medical mistakes by lack of support of the medical profession. After the healthcare workers do what is reasonably possible to prevent and eliminate mistakes, we must accept that mistakes will nevertheless happen. This should be understood by all concerned with medical treatment. There is always cause for correction and improvement on the part of the public, patients, physicians, and administrators, but never cause for punishment.

Patients make the greatest mistakes of all if they are not as informed and careful with their health than as they could be. Need for medical treatment may well be due to mistakes people make in not taking care of their health and their health care systems. People are overweight, smoke, drink alcohol, have unhealthful lifestyles and belief systems, fail to exercise, do not follow medical orders, etc. In this case, negligent patients seem to rarely think about their responsibility for their health, though the negative impact of not taking care of themselves sufficiently might be greater than that brought on by healthcare workers' inevitable errors. Here one may speak of the irrationality of believing that medicine and the physician can perfectly correct all of the disorders caused by patients' own poor lifestyle. In this sense, this is also a form of the fallacy of perfectionism on the part of the patient.

In all of the cases above, fallacies in regard to caring and not caring are the result of uncritical thinking. What is also revealed is the importance for the patient to be responsible to himself or herself (self-care) as well as caring toward the healthcare givers.

It is this that would help to generate positive mutual caring in the context of medical care instead of the one-sided view that the medical profession must alone be caring to the patient. For the best emotional and medical outcome the patient must be reciprocally caring to the healthcare workers. People often, or typically, do not show appreciation even if a healthcare worker bears extreme effort and sacrifice in saving their health or lives. When the cared-for do not show appreciation for the one who cares, it also undermines the mutuality of caring that, while not necessary, is nevertheless important for personal caring. Otherwise it puts caring on an impersonal duty level.

Case example: IVF Society of Austria Survey, Sept. 30, 2004 Meeting.

Patients in reproductive medicine reported the priority patients give for care in the following order:

1. Caring on the part of healthcare workers.
2. Professional competence.
3. Success regarding outcome.

This means that it is more important to be caring than competent or even to have a successful outcome! This is surprising but reveals patient's priorities.

Supernatural caring (Metaphysical caring, agape). Supernaturalism means beyond science, beyond knowledge, beyond evidence or proof, in short, beyond what we do know. Basically, a category-mistake, misuse of language, e.g., personification such as: a caring Buddha, an angel, god, or a "caring" universe is involved.

The demanding versus the caring attitude. It is a logical point that one cannot give to one who will not receive. One cannot demand that which can only be given by choice, otherwise it is not choice. In this sense, one cannot give to a demanding person. What is taken cannot be given. The caring aspect is removed by turning the need or request into a demand. A demand allows no alternative for the caregiver – and shows lack of concern for the caregiver. The demand for a personal or loving gift is a contradiction. The demand for personal medical care, by definition, cannot be given. It can only be complied with, forced or extorted. One may request one's right to medical treatment, etc., but demandingness is always an abuse, especially when one has no right to what is demanded. It reflects an uncaring attitude. One may have a right to treatment, but not a right to abuse to obtain it. A right to the sort of medical care that one assumes one has cannot therefore be given to one. Ungratefulness and lack of appreciation undermine the mutuality of a caring relationship. To be caring to the ungrateful can be misdirected by spoiling the cared-for or making them more ungrateful or dependent. The ungrateful patient expects and demands undeserved care and takes little responsibility for his/her own health.

Uncaring: takes the form of dislike, hate, apathy, indifference, ungraciousness, cruelty, unfairness, bad attitude. Thus one is not prepared to help. Not caring is not

merely a neutral stance, but rather a negative emotion. The dehumanization fallacy is the fallacy of treating humans as if they were inanimate “Another cancer patient” is to treat one as a classification and statistic. It is a form of not caring. The personification fallacy is to treat things or animals as if they were human and in the context of care, one may regard things as more important than people.

Unrealistic caring. The physician or healthcare worker may be personally and emotionally devastated if over-involved with the patient in regard to every treatment or when involved with a death. This may cause the healthcare worker to distance himself or herself from the patient so as not to be so negatively affected. One need not do so. One can still be caring if one understands that one must accept reality that people do die including oneself and that not all treatment and operations are successful. But this can only be successfully done if one has knowledge of a sound theory of emotion. If one has done all one can to prevent disease and death, one need not have negative emotions. The physician as physician especially does not need to feel guilty. Those who have done nothing to prevent illness, or do not agree to organ donation at death, support military and war instead, are those who may rather think-feel guilty. Sympathy or grief on their part is merely hypocrisy.

Burnout Syndrome. Helpers cared too much and so were over involved. Often people who are over-concerned were influenced by humanistic and altruistic ideas or organizations, pacifists, or sensitive thinkers. They often receive too little in return, are over-criticized and unappreciated by those helped or their relatives. They become “helpless helpers” [44]. Without knowledge of emotions and care one becomes a helpless helper, burns out, or becomes ill.

Pity. Pity can be seen in various ways. It may be seen as a thought-feeling: for the suffering and misfortunes of others. *Mitleid* (German, literally sym-path-y), pity is not just a bodily feeling, but also an assessment of a negative state of affairs. The emotion produced may be positive or negative. Pity may lead to help and care, or to grief and desperation.

As a negative value term: it expresses disadvantage, shortcoming, or weakness. It characterizes bad, awful, terrible, matter for regret, miserable, contemptible, e.g., “what a pity,” “pitiful.” Pity may be merely a term of blame and condemnation without sympathy, care or concern. Pity may be with or without mercy.

As self-pity one is “feeling sorry for oneself.” Instead of accepting the events of one’s life, one sees them as negative and further negativizes them, e.g., “wallows in self-pity.” This is non-adjustive and makes matters worse. It is also an egoistic attempt to extort the sympathy and care of others.

9.5 The Cognitive-Emotive Theory of Caring

In philosophical literature the cognitive-emotive theory is the prevailing one, and its counterpart in therapy is the Rational-Emotive and Behavioral Theory (REBT). There is a fortunate collaboration here because philosophers can work out the theoretical exploration while the therapists provide the actual clinical experience (See *Journal of Rational Emotive and Behavioral Therapy*).

According to the Cognitive Theory of Emotions as we interpret it, emotion (E) is a cognition (C) that causes a bodily feeling (F). $E = (Cognition > Bodily\ Feeling)$. In ordinary language, “emotion” and emotion words refer to both cognitions and feelings. An analysis of emotion therefore requires an analysis of bodily feeling, emotion, cognition, and their relationships. A number of characteristics of aesthetic emotion may be deduced from the cognitive-emotive theory.

9.5.1 *Feeling*

Caring is not a mere bodily feeling. Because emotions involve cognitions, it is always a mistake to say, “I feel caring.” Ellis pointed out that it is more precise to say, I “think-feel” caring. F here can also refer to sensation and perception (hearing, seeing, tasting, etc.). If emotion were only a feeling it would not be intelligible [45]. Melden wrote: “There is no simple or single feeling one has, such that feeling anger [caring] consists in having it and nothing else. Anger [caring]. . . cannot be an internal feeling or state conceptually unrelated to the functions of intelligence” [46]. We may accordingly answer Wittgenstein’s question: “What similarity has my admiring this person with my eating vanilla ice and liking it?” [47]. We may note that “I like ice-cream,” is a taste (F), “I admire her,” is an emotion (E). We do not ask why we like ice cream, but we do ask why we admire someone.

The prevailing polarized view of “reason versus emotion” or “caring versus reason” is rejected. The dichotomy reason (cognition) versus emotion dissolves or is restructured once it is seen that emotion is cognitive, that cognition produces feeling: $(Cognition > F)$. The dichotomy is based on a faulty view of emotion. “Cognitive caring” is not a contradiction. Noddings view is also based on an opposition between emotion and cognition. She speaks of caring as an emotion, affect and attitude, but it can be none of these as she rather regards them as mere bodily feelings [48]. Nevertheless, both feeling and reason are embodied. Without a brain, there is no reason, and no feeling.

In contrast to the cognitive theory, care for Noddings is just a primitive bodily feeling. It does not involve knowledge, but is a non-verbal impulse [49]. It is like Hume’s sentiments of sympathy. However, if caring can just come, it can just go, like a headache or pain [50]. It is said to be a natural innateness like animals, such as cats, have. But cats cannot have human emotions as they lack our language and way of thinking. There is no emotion or feeling without some kind of cognition. Noddings fails to give a theory of emotion as a basis of her theory. If caring were innate so would love, hatred, and anger be and out of our control, and fatal. . . what they often are – without reason.

9.5.2 *Caring Is a Value Cognition Causing Feeling [Caring = (Cognition > Feeling)]*

“Cognition” does not refer to mentalistic “ideas” or “thoughts.” Instead, it refers here to non-mentalistic assessments involving value terms. These cognitions, then,

are statements consisting of self-talk, utterances, and language use. As care, anger and other emotions no longer exist as such, the letter E will be used to stand for (C > F), where C is one or more specific assessments.

Caring can involve rational or irrational cognition. The cognitive theory of emotion thus gives a therapeutically useful, as well as philosophically clear, picture of emotion. No essentialistic claims are made. The analysis of caring becomes an analysis of its diverse language-games. For one to be consistently caring one must deliberately and consistently assess that one will be the most caring (kind, attentive, concerned, etc.) possible. What caring will mean is determined by the definition one gives to it. A more adequate definition might include: (a.) communication in order to solve problems and conflicts when they arise, (b.) communication to enrich the relationship, (c.) acceptance of the other person in various ways, (d.) ability to encourage positive emotions, (e.) mutual trust, (f.) the humanistic use of humor that can help one adjust to one's situation and, as humor involves acceptance, create friendship, (g.) care for everyone if one sees that people are not to be blamed or that they only do harmful things out of ignorance [51].

9.5.3 Caring Is Based on Positive Cognitions

The emotive cognition is typically a value assessment [52]. The cognition in caring must involve a positive value term or assessment, e.g., "I think you are a valuable person," Basically caring is caused by our assessment that doing so is good. We may think of caring as helping. "Good," however, is a notoriously vague term. As it can mean almost anything, it may be seen as an empty or open-context term – like a blank check. Consider the statement by a physician, "I will give the best [caring] treatment to my patients." What will be done? No specific commitment is actually made. "Good" is meaningless until something is substituted for it. The philosopher, Derik Parfit, wrote, "We benefit someone only if we do what will be better for him" [53]. This is circular. It does not specify the value terms used.

By definition, caring expresses a positive value, which is already contained in the very word "caring." In expression caring becomes clarified. We can analyze the emotion in practice. The assessments involved in caring are diverse, but may be something like, "You are in need and so I will help you." Caring is made possible by the acceptance of reality and the motivation to improve the given situation best we can.

9.5.4 Emotions Can Be Changed

Emotion can be created or changed by creating or changing cognition. This is similar to a change by a different sensing-as, for example, hearing-as. Psychogenic pain is cognized pain. Change of emotion and caring may take place anywhere along the continuum of cognition to sensation. Caring can be changed by changing the value assessment. To care one must oneself have the assessment(s) to care on some definition of caring. Cultural encouragement and constant exposure to uncaring behavior

can produce the influence to be uncaring and the enculturated assessment that one need not care. Without the ability to create positive emotion there can be no caring. The ethical challenge is to gain insight into the consequences of being or not being caring.

9.5.5 We Cause Our Own Emotions: Caring Is Caused by Ourselves

One's caring is caused by oneself, not by objects or others. We cause our emotions by our value assessments of certain objects. No one can make one personally care or love, but oneself. Dewey states, "Even anger and hate are partly caused by us rather than in us" [54]. Caring must be done in the first person case: "I will care for others." One may always ask oneself, "Could I have been more sensitive and caring?"

On the cognitive emotion theory, one can deliberately commit oneself to love or care for others. This is necessary for a deep and ongoing caring relationship. One can count on the other as a partner, friend or caretaker. One can speak of uncommitted caring as one can speak of loose, uncommitted friendship. It is unreliable. Healthcare as impersonal law-bound care may be unreliable and limited in terms of time, amount and quality. And be based solely on financial negotiation.

One might only take on the role or appearance of caring because it is one's job as a healthcare worker, but this is role or pretense caring. It is not personal or first person case caring, but second and third person caring: "You require or they require me to be caring." This generates a different or more impersonal emotion of caring. It may be noted here that impersonal caring is still an emotion and is still caring. There can be negative emotions of mere "professionalism" or cold "objectivity." The "objective" sounding monotone lecture is similar to the emotion of boredom. Such a professor is not enthusiastic about his students.

If one helps others merely because of the money one thereby earns or because it is one's job or obligation to do so it will not generate genuine caring or enthusiasm. One form of caring involves being excited about helping another. Because of the many meanings of caring there are many emotions of caring. There is no caring as such, just as there are no emotions as such, but only "caring" assessments, which cause bodily feelings. What caring is for any individual depends on their known or implied definition of caring. The various definitions were given earlier.

Without an analysis of emotion few would have a clear understanding of what caring is. One may call this "blind caring." If asked, one cannot answer why one cares. One may have an attitude of personal caring without professional caring or identity caring, etc. Similarly, the notion of "helping" may be a personal, subjective helping or objective, impersonal helping. It can be a perfunctory act. It is like mere social politeness versus being genuinely concerned. It is hypocritical caring if personal caring is actually selfishness (self-caring). It is the unhumanistic smile.

Just as emotion is not innate or unalterable, neither is caring. Caring is not an innate quality of humans, but can be learned or unlearned by change of assessments

and understanding. We can radically change our caring behavior. Being uncaring often shows a faulty sense of goals and philosophy of life. It is therefore interesting that the literature on caring stresses the social aspect of caring and caring as a relationship. It also means that the investigation of caring belongs on the level of philosophical counseling.

9.5.6 The Passionate Stoics: Rational Emotion, Rational Caring

The Stoics did not reject emotions they only rejected negative emotions such as uncaring. Uncaring behavior would be “false judgment.” The position of Marcus Aurelius is not that we should have no emotions and so be without passion. Rather, he opposes violent excitement (an oxymoron) [55]. Have “good emotions” (58), and “happiness” (74). We could include in this the emotion of caring. Rational judgments produce positive emotions, for example, happiness (*eudaimonia*). Against the widespread characterization, Rist argues that the Stoics did not advocate apathy. On the cognitive-emotive theory, apathy is a negative emotion [56]. The wise person experiences the joy, happiness, and even exhilaration that come from living a rational life in accordance with nature [57]. Rist argues that they produce “rational feelings” [58], and that only “the picture-book Stoic wise person is devoid of passions” [59]. Concerning this Rist states, “Anyone who seeks ‘apatheia’ in the sense of total elimination of all feeling and emotion, is asking for a state when all activities, even mental activities, are suspended. Such a state would be equivalent to death” [60]. If one is not caring, one is not neutral, but uncaring.

9.5.7 Negative Emotion Changes with Feeling

Emotion can, to some degree, be changed by changing the bodily feeling (perception, sensation). Because caring is cognition, which causes bodily feeling, there is no unfeeling caring. A change in bodily feeling, then, can alter the caring. In regard to negative emotions, such as being uncaring and revengeful, change of the resulting feeling can do little to change the emotion. It is mainly the cognition that must be altered. If it were only the feeling no physician would get up at 3 o’clock in the morning to take care of a patient in emergency.

9.5.8 Negative Emotion Is Not Passive

Being uncaring is not passive like bodily sensations or bodily feelings. Because feelings are used metaphorically to refer to emotions, we may tend to regard emotions as being just bodily feelings and so as being passive. They are not. Even the sudden caring concern that seems to be groundless is based on numerous prior assessments. We are attracted by those who meet our prior preferences. We can reconstruct the experiences that lead us to have these experiences. In another sense, our assessments may themselves be enculturated. We are uncaring partly because we have learned to be so in the society in which we were raised. A reconstruction of the reasons for

being caring or uncaring is just another language-game, not a statement about what “really” is the case. But it nevertheless has its uses as with the correction of failure to care.

9.5.9 *Each Emotion of Caring Is Unique*

We can never have the same emotion twice. Nor can two different people have the same emotion twice or at all. The first reason for this is that there is no emotion as such. Secondly, for each emotion there is a different cognition (C) and a different bodily feeling (F). We have “ideas” constantly and cannot completely control the way in which they come to us. The same is true of feelings. Thus, again, for each emotion of caring there are different C and F. $Caring = C_1, C_2, C_3 \dots \rightarrow F_1, F_2, F_3 \dots$. Each instance of caring is to a greater or lesser degree different than every other one. Our cognitions do not stand still, and nor do our bodily feelings. And two people can only have a *roughly* similar emotion of caring.

Caring₁, Caring₂, Caring₃... can be distinguished by their different cognitions. “The production of the same emotion by different contexts is impossible” [61]. For each act of caring we must find the specific assessments and feelings actually had. A physician exhausted from night attendance and/or from irrational demands of patients will have different thought-feelings of caring. A specific act of caring will be some combination of diverse sorts of assessments and feelings. Thus, each specific occurrence of emotion (each language-game) must be examined separately. The above analysis hopefully provides a reply to Hoaglund’s complaint, “Philosophers have not really come to grips with the wide disparity between our simple emotion terms and our complex emotional life” [62].

9.5.10 *Rejection of the Release Theory of Caring*

Emotion is not a sort of mentalistic thing that can be “released.” We are wrongly told to “release” our anger, grief, jealousy, etc. Dewey states, “Experience is emotional but there are no separate things called emotions in it” [63]. And experience is embodied, so are cognitions, emotions, and feelings. The change of cognition takes the place of release. In any case, a well-adjusted person would care because it makes sense to do so in terms of consequences for the cared for as for oneself.

9.5.11 *Judgments Generally Involve Emotion*

Virtually all judgments involve emotion. Belief (judgment, cognition, scientific statement, etc.) itself may be regarded as an emotion. The formula for emotions is: emotions are cognitions, which cause bodily feelings. It would follow that any cognition would be accompanied by a feeling. And this is exactly what the Stoic, Chrysippus, held. It is not strictly the case that cognitions cause bodily feelings rather bodily feelings are part of cognitions. For him, all judgments involve feelings or emotions. There is no such thing as emotionless thought [64]. For Collingwood

also, all judgment and all of language, express emotion. Emotion and cognition unite [65]. “There is no need for two separate expressions, one of the thought, and the other of the emotion accompanying it. There is only one expression” [66]. We can now see that there are caring judgments. As the word-field of care shows, it may be involved in many judgments and emotions, e.g., love, help, etc.

9.5.12 *Metaemotion*

Altruism, caring and egoism are not causes. Only cognitions-causing-bodily feelings can be causes. Morality has largely to do with feelings. If benevolence is regarded as an emotion, it is not a cause of altruism, but a meta-emotion, an emotion causing another emotion, or more strictly speaking, one cognition-causing-a-feeling that causes another cognition-causing-a-feeling.

9.6 Caring and Negative Emotions

It has been argued above that negative emotions are due to irrational thinking. As a person has mostly negative emotions s/he cannot to this extent be caring. Physicians or nurses, who are overworked, frustrated with problems and demands, stressed, or burned-out cannot adequately provide needed positive caring emotions. A simple test of one’s professional emotional competence is the following: If one does not have positive emotions with colleagues, it is certain that one will also not have them with patients or others, and even with oneself.

Total quality management (TQM) is meaningless if one does not know what quality means. To know about quality, an open-context value term, one must know about both ethics and emotions.

The negative emotion of blame often blocks caring. With anger and revenge, blame tops the list of the foremost negative emotions. With such an emotion one cannot easily have, for example, personal caring, though one can have perfunctory tolerant professional caring. It has been argued that blame does not make sense because: 1. We cannot change the past or what is, and 2. People do harmful things out of ignorance (e.g., because indoctrinated or enculturated or uneducated). No one could have done otherwise than they did or they would have done so. To claim otherwise is to think one always has all knowledge and control of oneself. We do not have such knowledge, and especially not of emotion. If we cannot be certain what we will do in the future, how can we claim to know what we would have done in the past? The claim that anyone at any age and stage of development could have done otherwise is to judge from an unrealistic, ideal, after the fact perspective. We do the best we can from what we know regardless of how adequate. Although it therefore makes no sense to blame, it does make sense to correct behavior. We thereby substitute rehabilitative blame for retributive blame. We treat the worst patients, but we educate them to get out of their destructive behavior as well. Without blame or unfounded negative emotions one is free to love or be caring to everyone. Understanding is a form of caring. The more we understand others the less we can blame them. This

gives support to the physician's Hippocratic Oath requiring the physician to do no harm, and to treat people equally. However, this does not mean that the equality should be blind and ignore other relevant factors. One may not blame, but unconditional caring is self-defeating. It does not make sense to give care to all without regard to the consequences (see "Nighttrain to Lisbon" by Pascal Mercier). We may also have to psychologically and physically protect ourselves from them. One may nevertheless have a positive attitude without anger or bitterness toward everyone if one does not blame anyone. However, that we do not blame also means that those more capable have a responsibility to educate those who do not. The healthcare worker may serve as a model of caring.

9.7 Mutuality of Caring

It was earlier mentioned that for Noddings, caring must be reciprocal. "A relation cannot properly be labeled caring in their [reciprocal or mutual responses] absence" [67]. Groenhout agrees that reciprocal caring is required, even eventually of a child. If this were true it would possibly eliminate caring in most healthcare situations [68].

Caring relationships need not be mutual. One may be caring toward (for, with, of) another without reciprocation. The healthcare worker-patient, parent-child, teacher-student relationship may involve non-reciprocal caring. In love this would be called "unrequited love" or "pure love," a caring when nothing is expected in return. Otherwise love and caring are like barter involving egoistic benefit. Nor can one expect care to be recognized by the cared-for. One cares because it makes sense, not because one is thanked for it. Although it would be humanistic and supportive, patients often do not show appreciation being cared for. They may merely expect it, take it for granted, or demand it. They are far from appreciative caring. The cared-for may even be noncompliant or betray the caregiver. Noncompliance undermines reciprocity. Good Samaritan laws even had to be enacted to protect the rescuer from lawsuits by the rescued.

One can assess to love/care for someone though s/he does not or cannot reciprocate. This is especially true if we do not blame people, but if we rather seek to help better them. If people, including health care workers, do not know about how emotions work, they are to this extent not capable of fully caring.

9.8 The Patient's Hippocratic Oath

To avoid the shortcomings of caring mentioned above we may propose the following as the Patient's Hippocratic Oath.

1. Do no harm to yourself, the healthcare provider, or others.
2. Live a healthy lifestyle. Make intelligent decisions regarding risks and diseases.
3. Develop your critical abilities and other abilities and potentials to achieve the maximum quality of life.

4. Cooperate and participate in your own cure and recovery by inquiry and obtaining information to become as healthy as possible.
5. Find out what ethics is about and create a sound ethical system.
6. Learn about emotions so as to encourage positive emotions and eliminate negative ones.
7. Do what you can to promote medical treatment and research. Offer to donate organs upon death, do not oppose medical research for supernatural reasons, donate to research and other health organizations, etc.
8. Make sure you have good reasons for having a child and whatever is necessary to care for the child.
9. Contribute whatever is reasonably possible to the people of the world who are in desperate need of food and medicine or are otherwise desperate.
10. Honestly reveal to the healthcare worker all information required for treatment.
11. Cooperate with the healthcare worker regarding treatment including the following of instructions given.
12. Resolve differences by means of good communication, ethics counselors, or philosophical counselors rather than by appeal to punitive laws.

9.9 Empathy and Caring

Empathy can involve pity, to think-feel sorrow for someone or something because of the poor or depraved state they are in. One may or may not act to help “out of pity.” It is an emotion that may motivate, and is partly a negative emotion. It is a failure to accept reality and the fact that we can only do what is within our power.

Webster’s Dictionary defines empathy as: “Imaginative projections of one’s own consciousness into another being.” It is, however, often said that philosophical counseling is not to involve projecting one’s views, emotions or consciousness into another. It may be dangerous and indoctrinative to try to project or impose one’s views in this way.

Is empathy then having a similar emotion (pathos) to that of another? If so, can one genuinely do that without being the other and in the same situation? One gets the impression that “sympathy” may mean to have the same negative emotion as the other. If they are depressed, you are depressed. Caring as sharing another’s grief can also be debilitating (The German word *Sorge*, can mean both, care or worry in a fearful way; *sich sorgen um* means worry about, *sorgen für* means to take care of). If “sympathy” means *sym-pathy* (German *Mitleid*, “suffer with”), having the same negative emotions or feelings someone else has, Nietzsche is right in seeing it as life-denying. “Commiserate” means, literally, to be miserable with. Eisenberg even calls empathy, “emotional contagion” [69]. One should instead help without negative emotions. If one were to have sympathy it would preferably be holistic and humanistic sympathy, not just a feeling.

Some of our acts are sympathetic, others not. We have selective altruism and egoism. Should we have empathy for military or religious fanatics, for those who are anti-humanistic, anti-inquiry and hold dogmatic positions regardless of

consequences? Should we be empathetic with those who continually frustrate, oppose and undermine us? Whatever is the case, if philosophical counselors are to speak of empathy they need to define it and offer a clear and tested theory of empathy. The same would be true of vague value concepts such as “caring.” Like caring, “empathy” is an “emotion” and has here been similarly analyzed on the cognitive theory of emotion. There are, of course, a few theories and criticisms of empathy. In social work E Munro regards empathy as being unreliable [70]. In the context of care theory Tong wrote, “Empathy...can be useful for good or ill. The more I am able imaginatively to project into your psyche, the more I can help or harm you” [71]. With empathy one may supposedly come to a more complete understanding of another. If so, it appears to be a cognitive concept. But a full and deep understanding of another (e.g. *verständnissvoll* – full of understanding) involves much more than empathy and it may not involve empathy at all.

Another danger with the emphasis on empathy is that it seems to be regarded as a special non-cognitive, feeling form of intuitive knowledge [72]. Two objections to this are: 1. Empathy as a mere feeling may produce irrational self-justification: Something is true because we somehow feel that it is true; 2. According to the cognitive theory of emotion, emotions are not just bodily feelings. It would be a fallacy to regard empathy as just feelings, or bodily feelings. The widely accepted cognitive theory of emotion comes against the typical definitions of empathy. It may be noted that the German word, *Einfühlungsvermögen* refers to both feeling + cognitive ability to understand. We acquire a sensitive insight into someone or something and thus get into the very nature of the experience. It comes close to phenomenological philosophy.

Bohart and Greenberg edited a book on empathy in psychotherapy in which they conclude, “Research in the area has generally been plagued by confusion over operational definitions and lack of adequate measures” [73]. Different authors meant different things by “empathy” [74]. The definitions and mechanisms of empathy are thought to be unclear [75]. The question was raised as to whether or not empathy is even a distinct quality, and if not, it would not be measurable [76]. The general conclusion was that one does not know what empathy exactly is and that attempts to measure it have failed [77]. Four types of empathy were given: cognitive, affective, shared, and nurturant (supportive) [78]. Empathy was further defined variously as: person-centered promotion of safety and trust in the self, an intervention, bonding, restoring the relational interaction, “Gestalt”, reframing, group therapy, dialectical synthesis, narrative organization of another’s experience, existential concept, understanding or knowing of the other, unconditional positive regard for the other, sympathy, shared feelings with each other, same feelings as the other, having cognitive understanding of the other, non-judgmental acceptance of others as they are, immersion of the self in the other, co-construction of symbols to clarify and understand another’s experience, feeling and thinking as if one were the other, gain of access to the unconscious (Freud), “reflection of feelings” (Carl Rogers), concentration on what the other is feeling, saying, meaning in the moment, communication of another’s views back to them, communicative attunement, kindness, encouragement and justification of the other’s negative emotions. The sado-masochist can use

empathy to take pleasure in the pain of another and do so without sympathy [79]. The therapist can have empathy for another, yet not care about them at all. The main problem with the psychotherapeutic approaches is that they do not have a sound theory of emotions and lack critical analysis as would be had with knowledge of philosophical psychology. The closest account to this is the work of the cognitive psychologists [80].

In sum, empathy, like caring, is too vague, unscientific and unsatisfactory as a concept to base philosophical counseling or medical action on it. Barnbaum stated, “Teaching empathy should be part of the medical ethics curriculum” [81]. She assigned by lottery diseases for students to imagine they had and required them deal empathetically with such diseases. From the above we can see that this would be an impossible task. Better would be to learn about and apply a sound theory of emotion.

9.10 Summary

On the cognitive theory the question, “Why do we help others?” becomes, “Which cognitions are involved in altruism?” We help others because of the following: force, threat, guilt, duty, cultural expectation, actual reward, power, financial gain, recognition, pleasure, pity or sympathy, trade-offs, influence, etc. We may do unselfish things for selfish reasons, e.g., for affection.

What is called by Wolfgang Schmidbauer the “Helper’s Syndrome” is self-sacrifice to hide a lack of goals or an emptiness in one’s life. People with helper’s syndrome are not in touch with their true emotions. One may find oneself in helping an ill patient or one’s needy child in order to get in touch with one’s inner self. In helping, the physician may have lost the ability to be in a genuine mutual exchange relationship and interdependence, not an adult to adult relationship. Thus, resentment may develop [82]. On the other hand, it is also pointed out how altruism may be “negotiated” to the disadvantage of those who try to help [44].

It makes sense to care for others because caring and love are needed in the immediate and larger world. People wish to satisfy their basic needs, desires and wants as human beings and it is rational in terms of our goals and consequences to help them do that. As people, we act, have cognition, emotion and feeling. We would not wish to live in a world of either negative altruism or negative egoism, a world where no consideration is given to anyone, no flowers are grown or given. Perhaps this is what Hume partly meant by saying that sympathy cannot be further defined. Hume and others based altruism on emotions and psychological, factors such as sympathy. Altruism versus egoism is, then, part of larger questions such as, “What is the basis of ethics?” Altruism versus egoism, or caring is a fragmentary, narrowly focused issue.

Why should we help others? On the view of psychological egoism it is part of our character to do so and so has no rational basis. According to Dewey’s ethics, value terms reduce to naturalistic terms. “Good,” for example, refers to deliberately bringing about our informed wants and likes on the basis of adequate inquiry and

knowledge of consequences. On such a view, we would be altruistic because, in terms of inquiry and an adequate knowledge of the consequences, it makes sense to do so. It is a “rational altruism or egoism.” On this view we would be egoistic or altruistic, assuming the terms are clearly defined, whenever it is rational to do so in terms of the consequences. Similarly, JS Mill held that altruism is supported by our desire for harmony, a “feeling of unity” with others; because one seeks pleasure for oneself, by analogy, one ought to seek the pleasure of all [83].

Rational caring may be contrasted with irrational caring. Rational caring would include rational thinking, critical thinking (speaking), holistic philosophical thinking, humanistic thinking (ethical concern and care for humans, animals and the environment), knowledge of ethics and emotion. Without these abilities one could only have irrational caring, inconsistent or contradictory caring. One cannot be pro-killing or pro-war, or anti-medical research, anti-science and be a rationally caring person. *The creation of rational caring generates a new emotion.* Not caring, like apathy and depersonalization, are fallacies of negative emotions.

We live in a society in which we must interrelate with each other and so are concerned with each other. We are world-citizens. The problem of altruism and egoism is a holistic problem. It is a high-level problem of value and fairness. It is a problem of how to make the most adequate decisions possible for all involved. We would have enlightened management not because it makes a self-interested profit for the employer, but because it makes sense for all concerned. The assessments involved being based on reason and adequate inquiry produce an emotion of being civilized, of satisfaction in the knowledge that one has produced an intelligent social act of caring. To express this in another way, a rational or positive caring reduces to humanism. Humanism appears to be a useful guide upon which to base caring because its basic guidelines involve altruism, love of people, open education, free inquiry, free choice, freedom of speech, an ethics based on reason, consequentialism, enlightened democratic methods, anti-sexism, anti-racism, etc. It opposes enculturation, vague abstraction, indoctrination, censorship, morals based on fear and punishment, supernaturalism, appeal to authority, absolute values, etc. On this view, we are altruistic or egoistic not out of a feeling, or because of duty, but because it makes sense in terms of the consequences. This does not mean that ethics is a matter of achieving consensus. Consensus is the appeal to majority fallacy. That most people believe something does not make it true or fair. Consensus is a way of *not caring* about reasoned argument. It is also a way to retain the prejudices or supernatural beliefs of the populace.

Rational reasons for caring are fundamentally simple. People have wants, likes and enjoyments and these may be enhanced by our efforts. It makes sense to do so as we have interrelationships with everyone in the world directly or indirectly. We help others as world citizens, as humans. The negative side is to help others because they are in desperate need. The positive side is to enhance others to improve their knowledge, capabilities, aesthetic lives and living situations. To care about people is to help them be all that they can be. In the medical profession it translates into helping to rebuild the patient’s potentialities and trying to give the patient new goals or insights in life appreciation, even art. A Viennese surgeon of our acquaintance

does exactly that and has authored a book on the art of physicians [84]. Rebuilding potentialities is also one of the fundamental goals of philosophy and ethics.

Human ecology, humanistic medicine, and bioethics are forms of this caring. In this respect, one could say that caring is a passion for critical thinking (speaking) and practical, problem solving. In a naturalistic theory of ethics, the more we know the more we can bring about our informed needs and desires. To care is also to see what caring means in detail. This is a philosophy of caring, rather than only morals of caring.

An analysis of caring was seen to require an analysis of ethics, the self, causes of action, motivation, and emotion. To analyze caring is to analyze how people think and behave generally. It is not just an isolated quality. It was also shown how caring may be redefined and based on a naturalistic, humanistic theory of ethics.

Philosophy and Ethics of Personality involve the emotion of care. From the above analysis of emotion and care theory we may create an area of investigation called the Philosophy and Ethics of Personality or Character. It includes the area of philosophical psychology, philosophical counseling, analysis of character and the traditional virtues. We have seen that a positive personality is needed for the emotion of caring. As the personality of the physician is like the so much needed drug for the patient. . . it is of eminent importance to work on it professionally and privately.

This relates to the question sometimes raised as to what kind of people should we be? It involves also the question of the use of medicine and sperm banks, etc. and the possibility of having designer children. What personality qualities and goals ought an individual seek to develop and for what purposes? How can one think more rationally? To what extent can one eliminate negative emotions and develop positive ones? How can one become more ethical? How can one live a more aesthetic life? Philosophical Practice (philosophical counseling) is an attempt to guide one regarding such questions. Rational caring is one of the personality characteristics that may be considered for adoption.

To determine what caring is presupposes knowledge of ethics, emotion and philosophical critical thinking (speaking). This is the area of Philosophical Practice. We saw that caring is not itself a theory of ethics. It is an emotion. Caring leads to a wider and deeper philosophical investigation.

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