

CARING - COMMON AXIOLOGICAL PRINCIPLE IN EDUCATION AND MEDICINE

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Abstract

Caring is fundamental for all human activities, including professional ones. The concept that describes most accurately the care offered in the public domain is ethical care. Despite the differences between the practices of the two domains, medicine and teaching, there are also similarities from the perspective of the act of caring. Both are cognitive, technical and ethical, relational activities. In formal education, the principle of care can be related to the following aspects of the didactic process: teacher-child relationship, the management of school groups, the choice of teaching strategies, construction of the curriculum. In medicine, the value of care is most often analyzed from three perspectives: its introduction in the curriculum, the conduct of research from the perspective of all the parts involved in the medical act (medical staff and patients) and building an attitudinal and behavioural portrait of the care bearer.

Key words: care, ethical care, medicine, teaching profession

1. Introduction

When choosing this theme, we started from the premise that care is essential for all human activities. If application of the care principle at the level of the family belongs to human nature, as we talk about biological, blood ties. At the professional level, the situation is different and care should be cultivated, formed. Nel Noddings (1984) best explained the different forms of care. Noddings separates between natural caring and ethical caring. When I care for someone because "I want" to care, I am engaged in natural caring. When I care for someone because "I must" care, I am engaged in ethical caring. Natural caring applies at the level of the family, whereas ethical caring applies at the level of occupations. Obviously, "ethical caring" is a form of caring that is

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more deliberate and less spontaneous than natural caring (Tong, p. 164). What does 'to be caring' mean? Allmark (1995, p. 23) provides the following explanation: the fact that we care does not make us 'caring' in the sense that the term is used when it conveys moral approval. For someone to be 'caring', at least two additional components are required: first, the person must care about the right things, have the right set of values. Second, the person must care in the right way, display sensitivity and skill.

In the usual sense, 'to care' has multiple meanings: to supervise, to teach, to give attention to, to give help, to be available. We notice, at a first glance, the ambiguity and wide range of coverage. Linguistically speaking, the word "care" appears in expressions either as a noun, a verb or an adjective. So, what is 'care'? An attitude, an aptitude, a process, a feeling, all of these together? Despite the abundance of speeches, there are still many problems related to definition, respectively in terms of the explanations of the occupational context. Philosophically speaking, Van Hooft (p. 83) proposes the notion of 'deep caring', developed from the ideas of Aristotle, Karl Jaspers, Emmanuel Levinas and Martin Heidegger. This can be understood as a fundamental structure of human living, which would be the basics for these caring attitudes and behaviours and also for any sense of obligation that we might experience as arising from traditional moral norms. This form of motivation is characterized by a lack of recognised motivation of the human agent, a deep and inchoate quest, which does not have definable objects.

2. Theoretical approaches to caring

2.1. Relational approach to caring

Although many thinkers have conducted research upon the topic of caring so far, this concept has gained increased visibility with the resignifications brought by the feminist authors Nel Noddings and Carol Gilligan, at the beginning of the 80's. For both of them, care can be understood as a complex act, developed between two parts: the one who cares and the one who is being cared for. In her study, *In a different voice*, Carol Gilligan (1982) emphasizes the gender perspective, highlighting the different ways in which men and women face moral dilemmas. Based on Kohlberg's model about the moral development stages and analyzing the answers of boys and girls for the Heinz dilemma, she has concluded that the feminine ego gives priority to the interconnections with others, whereas the masculine ego privileges correctitude, fairness and justice. Therefore, care is mostly associated with women, the social and family practices encouraging this conduct.

Noddings names these three requirements for caring (1984, pp. 11-12): the carer (*the one who provides care*) must exhibit engrossment, namely, have an altruistic attitude towards the other's needs; the carer must exhibit motivational displacement and the person who is cared for (*the cared-for*) must respond in some way to the caring.

2.2. *Caring as societal practice*

A new wave of feminist authors eliminated care from the speeches promoting a gendered approach and included it in larger contexts. According to them, we should stop care to feminine morality and exploit it as a politic principle. The decisive contribution belongs to Joan Tronto, who saw care as a societal, cultural, institutional practice. For Tronto (1993), care is defined as *a species activity that includes everything we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible*. That world includes our bodies, ourselves, and our environment, all of which seek to interweave in a complex, life-sustaining web (p. 103; *italics in the original*). In other words, *the care* is a general problem, which concerns us all, being in relation with all our other activities, not only our private ones. Only by acting together can we satisfy the needs for care, which are always increasing.

The four phases of the care process are (Tronto, 1993, p. 109): the first one, *caring about* implies the recognition in the other one of the need for care; the second one, *taking care of*, refers to the responsibility towards the others and projecting different ways of actions; the third, *care-giving*, implies conducting a concrete activity, eventually together with the care bearer, because of the need for care to be satisfied; the last phase, *care-receiving*, refers to the reactions of the receptor in relation with care giving. The four phases must fit together into a whole. According to these phases, Joan Tronto numbers the fundamental values in caring (1993, pp. 129 - 133): attentiveness, responsibility – not only legal, formal, but 'rooted in biology', competence and responsiveness.

Even if in caring we have both poles, bearer of care and receiver of care, the attention is often only on the bearer. Lindemann (2003) appreciates that most adults are perceived only in the first aspect, ignoring the second one. They seem not to be aware of the situations in which they receive care, which are not few. In praxis, care receiving is also important. There is no human service without receivers of care, as there are no jobs without bearers of care. Receiving care is an act with powerful significations, which needs appropriate psychological attitudes (p. 508). This perspective can be capitalized in medicine and education, because it focuses on the clients' perspectives.

3. Medicine and teaching as professions

The two activities we shall refer to, medicine and education, are domains of maximum importance in a society. We present below some similarities and differences between these two domains, from the perspective of care praxis.

3.1. Similarities

Firstly, in both domains, medicine and teaching, caring starts from a fundamental value: health for medicine, a physical, vital value, and spiritual development for formal education. These values are on different positions in Maslow's pyramid of needs: health is at the base of the pyramid, as a basic, priority, urgent need, whereas forming is a self-realisation need, at the top of the pyramid. At a first glance, people can live without formal education, but not without health.

Secondly, both are professions in which relational skill is important. The professional, official, institutional relation implies the care relation, too. The bearers and receivers are involved in the process, cooperation being the variable that makes healing (in medicine) and development (in education) possible. The two actors are influencing each other. Although there are asymmetrical relations in which the teacher, respectively the doctor, has deontic and cognitive authority, the attitude of the patients and the students as receivers of care is not to be neglected.

Thirdly, from the perspective of the aspects mentioned above – axiological and relational – both professions are equally defined as missions, vocations, arts. The ethical and moral dimensions of these professions gain great importance.

3.2. Differences

The expertise (as an ensemble of specific knowledge, abilities, methods and technologies) differs in the two domains: work in medicine is strongly mediated by technical aspects (instruments, medicines), while in teaching there are no diagnostics, recipes or prescriptions to be followed. Because caring is concerned with the welfare of others, it is primarily a *moral* endeavour. But, medical caring also requires the technical for its performance (Ludmerer, Fox, 2001).

In some contexts, the receiver of care is passive, even unconscious in medicine, undergoing care without having any significant contribution. In the *didactic profession*, *an entire cooperation with the client* is mandatory for achievement of the desired results. “A surgeon can heal the disease of a patient who is sleeping during the intervention, an advocate can defend successfully a client who stays dumb during the case” (p. 228, Labaree, 2000). This is not possible in the didactic profession.

The system of offering care is different: in medicine, the patient moves from the family doctor to larger hospitals; in teaching, the client is kept in the same place for a long time, getting through “the journey” according to his virtues and efforts. The work conditions of the teacher engage him to *structural isolation*; working ‘between four walls’, being the only professional in the room is not a simple matter.

The nature of care results is different: in medicine, more concrete, tangible, often on the short term; in education, ineffable and on the long term. Hence, the chronic uncertainty about the effectiveness of teaching. Who guarantees that the teacher has selected the best contents, methods, teaching resources? How are the effects of his work established?

The frames of the meetings (number of participants, duration, frequency) between the bearers and the receivers of care from the two professional areas are totally different. The doctor has interventions well limited in time, at large intervals, with the same client and within a vulnerable context, whereas the teacher works with the students every day, relying on the physical and psychological condition of his students.

4. Caring in the teaching process

Many discourses on education have a fatalistic tone. We are in “the twilight of duty” (Lipovetsky, 1996), society and family are no longer what they used to be and as such the school functions traverse a reconfiguration process. Fernando Savater an original perspective on the relationship between parents and children, educators and youth. We live times of intriguing changes, where the adults have abdicated the role of parents and want to be the friends of their children, this involving serious consequences for forming the moral conscience of the youth. The dissolution of any form of authority in the family and at school is as harmful as can be, because it requires paternalistic politics from the government (*The courage of teaching*, 1997, p. 61). A father or a teacher must be also a little unbearable, because otherwise he is not good at anything (1997, *Ethics for Amador*, p. 16).

Regarding our subtheme, some questions arise: what does care in education mean? How do we recognize it? Straits (2007, p. 174) has established a number of indicators of caring for college instruction, of which the most important are: being available to students, respecting students as individuals, willing to give extra effort, welcoming questions in class, inviting discussion outside of class, getting to know students, wanting students to learn/succeed. Isenbarger and Zembylas (2006, p. 132) have established a taxonomy of caring, namely: pedagogical caring – caring about children’s academic expectations; moral caring – caring about the values communicated in

learning; and cultural caring – caring that communicates the norms of the culture in which the school/ classroom is part of.

In the teaching process, we can speak about the teacher's care in relation to the following problems: cultivating the relations with students, choosing the teaching strategies, class management and the construction of the curriculum.

4.1. Relationships with students

Doyle and Doyle, (2003) found two perspectives on the teacher-student relationship: caring for students and caring by students. While the first one is relatively easy to explain, the second one sends to care as metacognitive activity: “students must be not only be cared for, but they must also think, plan, implement, and reflect on how they are involved in caring for others” (pp. 260-261). However, in general, the educational relationship is a relation of caring between the formal initiator of care, the teacher and its receptor, the student. Referring to the teacher, Guzman et al. (2008, p. 488) present two ways in which teachers may act: teaching from the heart and teaching with a heart. Despite the apparent subjectivity of the terms, they are very clearly defined. Teaching from the heart is associated with single-loop caring or caring visibility (p. 495), meaning teachers who simply perform tasks for and with their students efficiently. Teaching with a heart is associated with double-loop-learning or caring presence, the ability to perform the assigned tasks over and above set standards. This form is the essence that makes teaching a form of caring.

What does care mean in the teacher-student educational relationship? It means building the relationship based on emotional labour (Isenbarger & Zembylas, 2006, p. 123), with teachers engaging in efforts to modify and control negative emotions, for the purpose of expressing only those emotions that are socially acceptable. This is not very simple, as good management of emotions is needed.

Some details are also required. Caring is not to be confused with love, or being intimate with students. The teacher-student relationship has particularities generated by the tasks of the teaching/learning process. Also, caring does not mean indulgence and overlooking mistakes.

4.2. Choosing the teaching strategies

The collaborative teaching techniques, collaborative learning and active learning are useful. Many psychological theories (Jean Piaget, Jerome Bruner, Howard Gardner) could be used from the caring perspective, whereas they start from the data of the person to be educated, from the empirical knowledge, presenting experimental evidences. The theory zone of proximal

development (Leon Vâgotsky) relies on the special relation between child and adult. What the child learns by himself is different as rhythm and performance from what the child can learn when assisted by adults. Offering help is essential.

4.3. Class management

The two conditions of the ethics of care, specified by Allmark (1995), apply very well in the following areas: establishing punishments and rewards, organization of the work in the classroom, management authority. For Watson (2010, p. 525), classroom management is a moral enterprise.

4.4. Construction of the curriculum

When we say curriculum, we have in mind the wider meaning of the concept, namely a series of objectives, contents, teaching strategies and assessment. The curriculum is not neutral from the ideological point of view (Apple, 1979). As such, teachers must manifest good judgment and empathy in dealing with sensitive issues such as money, family, religion, socio-occupational status of parents.

Caring is important not only at the elementary and secondary level, but at the university level as well (Guzman et al., 2008, Sumsion, 2000, Straits, 2007). In fact, the instauration of a climate in which caring is recognized as valuable in teacher's training institutions has long term effects, in the sense in which graduates, the future teachers, will replicate caring conduct in their professional activities. Sumsion (2000) takes certain concepts from Tom (*deliberative relationships, transparency and presence*) for optimizing the relationship between university teachers and the students-prospective teachers (pp. 175-176). *Establishing deliberative relationships with students* includes the metacognitive ability of the university trainer to impugn his own behaviour in front of students, reflect upon it in such a way as to consider long-term consequences. *Transparency* means to be honest in relationships, to constantly explain to students the actions conducted and the motivations behind them, in order to be fully understood.

Presence can have many meanings. A first meaning sends to being a genuine person in our interactions with others. The most essential element is to enact the belief that real people do the work we do. The second sense refers to sustained attention or 'a total commitment to being present' in the moment (cf. Bateson).

The advantages of creating a care-based community (Sergiovanni, 1994) in school can show on many levels: on the cognitive level, Sanacore (2004) presents proofs regarding increased performances in literacy learning. From the behavioural perspective, the student learns a series of values that can perpetuate and apply in the social relationships they develop. At the emotional,

motivational level, the gains are the biggest, by developing a sense of security and belonging, as a prerequisite for building a positive identity. The young people will form what is known as emotional intelligence.

There are also certain disadvantages for students: it is possible that, while focusing on care, the teacher may give priority to the affective, to the detriment of cognitive performance. Also, there are some difficulties for teachers, too: burnout (Nias, 1997), workload (Sumsion, 2000), inducing the feelings of guilt since we cannot meet all the needs for care (Hargreaves, 1994).

5. Caring in medicine

We often note discourses on the erosion of the traditional values of the medical profession. We start from a paradox that Tong reports (1997), a paradox which describes the contradictory context in which the physicians should provide the standard of care. Thus, the author says, it is very difficult to explain what good medicine means today: “On one hand, we worry that the *art* of medicine is dying and that clinicians lack such human qualities as empathy, compassion, and the ability to communicate. On the other hand, we express concern that if the *science of* medicine is not kept alive and vigorous, clinicians will be unable to treat, let alone cure or prevent our diseases” (Tong, 1997, p. 153).

Daniel Goleman noted, in his book *Emotional Intelligence* (2000), that medicine in modern society has defined its mission as being to cure diseases and to ignore the state of the patient. Medical staff often ignores the patient’s emotional reality, even if it makes them more vulnerable to disease (p. 217). However, the same author adds that beyond humanitarian arguments there is scientific evidence (Robert Ader, 1974, David Felten et al., 1985), which attests that a positive state of the patient impacts the evolution of his health condition. Emotions have a powerful impact on the immune system. There is an inextricable link between stress, anxiety and vulnerability.

Herbert Adler (2002) looks upon medical care as a socio-physiological process. This interesting domain, socio-physiology, relies on sharing physiology between people who are involved in a meaningful interaction.

In several medical researches, caring is more frequently linked with nurses’ activities. Is this a sign that doctors let subordinates account for the psychological training of the patients, their affective accommodation with the disease, themselves focusing on more important elements, such as diagnosis and treatment? In the medical act, the technical, cognitive, but also axiological, social components are combined. The manifested care for patients is a sign of dignity and mutual respect.

We have identified three fundamental elements of ethical caring in medicine, which form a system. A first element is education. Attitudes and behaviours related to caring are learned. Thus, it becomes very important the presence of the subject of caring in the formal curriculum of medical schools. Lown and his collaborators (2007) have conducted a study concerning the perceptions of deans and leaders on care in medical education (p. 1514). Most respondents believed that their schools strongly emphasized caring attitudes. At the same time, 35% thought caring attitudes were emphasized less than scientific knowledge.

Donia R. Baldacchino (2008) has integrated a study unit to emphasize the spiritual dimension of caring within the curriculum of nursing education, at the Institute of Health Care, University of Malta. The introduction of this unit had an impact on three levels (p. 505): personal, academic (at the cognitive level) and professional (becoming more sensitive to the patients' needs).

The second element is *research*: building a relevant research base that includes studies from many perspectives of the caring bearers, of the caring receptors and so on. It is necessary: the bioethicists' perspective, as specialists in ethical caring and ethical medicine; the medical school leaders' perspective upon care, as important voices in the construction of the curriculum; the medical staff's perspective: doctors, nurses; the patients' perspective. So far, many studies (David Hatem et al., 2008, Quirk et al., 2008) have proved that the doctors and patients' points of views about caring are different.

The third element is *the operationalization of care*. The first two components of the system, education and research, provide elements for sketching an attitudinal and behavioural portrait reflecting the practitioners' understanding of what caring means. As already noted, caring is a complex concept, implying numerous facets. It covers a large number of axiological, emotional, intellectual, behavioural and relational dimensions. What does to manifest care in medicine mean? It means to have *caring attitudes* (Lown et al., 2007, p. 1515,) understood as feelings and opinions arising from values that affirm the importance of understanding others as individuals with unique needs, in the context of individual, community, and cultural relationships. We present some examples of attitudes and behaviours (Lown et al., 2007, p. 1515):

- accepting responsibility for their professional role and seeking collaborative participation of patients, family/significant others, and colleagues in health care relationships;
- demonstrating empathy, communicating sensitively in response to the patients' and families' histories and needs, engaging in mutual decision making;
- committing to ongoing self-reflection, and welcoming feedback for continued personal and professional growth.

Quirk et al. (2008) prefer to present particularly the sensitive moments, in which caring is absolutely necessary. Caring, procedurally speaking, is closely associated with reduced malpractice litigation, adherence to treatment and even symptom relief. Generally speaking, caring is needed, but some moments are special due to their emotional load (Quirk et al., p. 359): discussing the transition from curative to palliative care, delivering bad news (cancer), and discussing a medical error (misplaced test result).

Conclusions

We state, in the end, that caring is a complex attitude, delimited at various levels and involving a special relationship between two poles: the care bearer and its receptor. Understanding of the caring process as societal practice paves the way for various opportunities for action in all sectors of social life. Caring is not an abstract principle, because it generates problems according to the professional context. Both in medicine and teaching, caring can be perceived as a key-value from which to start the defence and promotion of other values.

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